JEFFREY WARD, MD
REHABILITATION MEDICINE / PAIN MANAGEMENT
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PATIENT CONSENT FOR TREATMENT

1. I voluntarily consent to health care treatment by Dr. Ward. I am aware that the practice of medicine is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations.

2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the provided Privacy Practices.

3. I authorize payment of medical benefits to Dr. Ward for services rendered.

4. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

5. I have received a copy of the Privacy Policy.

Please sign here: _____ Date: _____