SLEEP MEDICINE SPECIALISTS OF SOUTH FLORIDA

CONSENT TO TREATMENT

I, _____, hereby authorize Sleep Medicine Specialists of South Florida P.A., the attending physician, or the physician designated by him or her and other employees to examine and treat me. I also authorize such treatment and procedures as deemed necessary by the physician, including but not limited to sleep studies, the taking of X-Rays, medications, blood samples, urine samples and other therapies.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has been made or implied to me as to the results that may be obtained by examination and treatment.

I HEREBY CERTIFY THAT I UNDERSTAND THE ABOVE AUTHORIZATION.

_____ _____

Patient (Sign and Print) Date

_____ _____

Guardian/Responsible Party if minor (Sign and Print) Date

_____ _____

Witness (Sign and Print) Date

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