Priority Medical & Rehab Centers, LLC
10778 Wiles Rd.
Coral Springs, Fl. 33076
(954) 346-5750

CONSENT TO MEDICAL/CHIROPRACTIC CARE

Please read this form carefully and completely before signing it.

I,_____, understand that I have a condition that requires medical treatment.

I, authorize Doctor(s), at **Priority Medical & Rehab Centers, LLC** to determine what kinds of diagnostic procedures (tests) must be done in order to learn more about my condition. These may include x-rays, blood pressure tests, or other routine tests. I understand that if my doctor advises a more complex test, or one which has special risks, that it will be explained to me. Further, I authorize the personnel of Priority Medical & Rehab Centers, LLC to assist in giving the test which my doctor may order.

I also authorize my Doctor to determine what kind of treatment is to be given and to perform such procedures as he/she may deem necessary, in his/her professional judgment, to preserve my health.

Additionally, I authorize the personnel of Priority Medical & Rehab Centers, LLC to assist in giving, or to administer the therapy which my Doctor may order. I fully understand that the medical tests or treatments may involve certain unavoidable risks.

I understand that the practice of medicine and surgery are not exact sciences, and acknowledge that no guarantee or assurance has been made to me as to the results of treatment or examinations.

I certify that I have read this form, and have had it explained to me, and I certify that I fully understand its contents in their entirety.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Printed Name Witness Signature

_____
Printed Name