

**BABA HEALTHCARE, INC.**  
964 S. WICKHAM RD.  
SUITE 1  
W MELBOURNE. FL. 32904  
321-956-7370

**PERMISSION FOR TREATMENT**

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by BABA HEALTHCARE ,INC.deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION AND ASSIGNMENT**

I hereby authorize BABA HEALTHCARE, INC. to furnish information to Medicare/Insurance carriers concerning my condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) Insurance Carrier(s) /Medicare to make payment directly to BABA HEALTHCARE, INC. for medical/diagnostic surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency or for any returned checks.

I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**DESIGNATED RELATIVE**

I have designated: Mr/Mrs/Ms. \_\_\_\_\_  
(Relationship to patient)) \_\_\_\_\_  
Phone # \_\_\_\_\_

For release of my health information/medical status if needed in the future.

Signature \_\_\_\_\_ Date \_\_\_\_\_