BABA HEALTHCARE, INC
Geetha Priyanka, M.D.
948 South Wickham Rd. Suite 103
West Melbourne, FL 32904
P: 321-956-7370 F: 321-956-7873

PERMISSION FOR TREATMENT

I, 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 BABAHEALTH, INC. for medical/diagnostic surgical benefits payable for the services rendered. I understand that nay unpaid balance not covered by this policy will be payable to me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for any charges incurred if my account I sent to a collection agency or for any returned checks.

I understand that Medicare and/or other insurance carriers do not cover all my office services/procedures. I agrees 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 the release of my health information/medical status if needed in the future.

Signature______________________________ Date: ____________________