Devang Shah, M.D.
Daniel Rothbaum, M.D.
Natasha Taylor, PA-C

Atlantic Ear, Nose & Throat, PA suggests that the POA or Health Care Surrogate complete this Consent to Treat an Impaired Adult Form in the absence of other documentation authorizing treatment. This gives legal permission to treat the adult if you cannot accompany the adult to an office appointment.

The law requires us to receive permission from the POA or Health Care Surrogate before treatment of illness or injury that is not life threatening. If this form (or appropriate substitute) does not accompany the person bringing the impaired adult in for treatment, the POA or Health Care Surrogate must be contacted prior to treatment.

Consent for Medical Treatment

I ________________________________ do hereby state that I am the POA or Health Care Surrogate of
(POA or Health Care Surrogate)

___________________________, born on _______, who resides at ____.
(Patient Name) (Patient DOB) (Patient Address)

I authorize ____ who resides at __________________________________
(Temporary Guardian Name) (Temporary Guardian Address)

to be present during visit and to act in my behalf in authorizing and consenting to all medical and surgical care, medical procedures, and/or diagnostic tests for the above named adult. I agree to pay for all services provided to adult mentioned above in my absence.

This authorization shall be effective until __________________________.

Signatures

_________________________________ ______________________

POA / Health Care Surrogate Date

_________________________________ ______________________

POA / Health Care Surrogate Date