Personalized
PAIN AND SPINE CARE

Consent to Treat Form

1. I_____(patient name) give permission for IBEX MEDICAL SOLUTIONS, PLLC (dba **Personalized Pain and Spine Care**) to provide medical treatment including medical evaluation, diagnosis, physical examination, laboratory testing, counseling, and treatment. I have the right to discuss any preferences that may affect my treatment.

2. I allow **Personalized Pain and Spine Care** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - Personalized Pain and Spine Care will have to send my medical record information to my insurance company per their policies.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

_____ _____
Patient/Responsible Party Signature **Date**

_____
Printed Name

_____ _____
Witness **Date**