Dynamic Arthritis Care Clinic, PLLC
Carlos E. Ramirez, M.D.
Board Certified internal medicine & rheumatology

Treatment Consent Form

Patient Name: _____ DOB:_____

I hereby authorize Dynamic Arthritis Care Clinic to treat me or my dependent.

I understand that any treatment/ procedure other than an Office Visit (i.e. intraarticular injections) may not be covered under my copay but might be applied to my deductible.

Acknowledgement

I have certified that I have read and fully understand the contents of the permission for the treatment and I agree to pay any balance that is applied to my deductible. I also understand that I am responsible for the cost of any testing done for me as required or referred to an outside lab and that the billing of such services is not included in the billing by Dynamic Arthritis Care Clinic but will be billed independently by the outside lab.

_____ _____
Signature Patient/ Responsible Party Date

_____ _____
Signature Witness Date