Consent Form

I consent to treatment by my attending physician and/or such physician and assistants as may be selected by her to diagnose and treat the condition or conditions from which I am suffering by such means including diagnostic exams, testing and in-office procedures as she believes indicated by her studies in my case.

I authorize, Adriana Krywiak DPM, CFMD, QBT/Integrative Health Management to possibly submit any and all health care information, which may include drug and alcohol history and HIV status to my health insurance program for their review in certain cases. I understand that it is my responsibility to know the benefits of my insurance plan. I also understand that some services, tests and consultations may not be covered by my insurance plan and that I am financially responsible for any services that are not covered and do not fall under this category of my plan.

By signing below, I am also verifying that I have a legal authority to authorize medical treatment.

Signature or Patient or Legal Guardian Date

Printed Patients Name

Witness