

## **BLISS SPECIALTY HEALTHARE GROUP**

Your Health, Our Priority Tel: 407-704-1771 | Fax: 866-341-7847

## **CONSENT TO TREAT**

Patient Name:	DOB: _	
From: Bliss Specialty Healthcare G	Group	
mobile multi- specialty group who homes, assisted living facilities an art care to any resident in need. N	ialty Healthcare Group to be part of your or provide wound care and dermatology send private homes. We make every effort to wost of our clientele are elderly and have stay in the comfort of their homes while t	ervices to clients in nursing o provide excellent, state of the difficulty leaving where they
well as they used to. It's an inevit wound healing and recovery. The help patients heal and remain fre	the largest organ on your body. And you able effect of aging and most times requi refore, our service is invaluable to the clie e from unfavorable skin conditions! We p e health, families, caregivers, nurses, and	re intervention to promote ents that we provide it to. We provide weekly visits to our
and as part of skin care. These pro treat, decrease infection or to dec cryotherapy, biopsy, cauterization conditions, Incision and drainage shavejust to name a few. Don't injectable to minimize pain and m	pecialists may do several procedures over ocedures are necessary to help your loved crease their risk of skin cancer. These may n, toenail debridement, removal of skin ta of abscess, foreign body removal, skin sci worry, your loved ones are anesthetized on nade comfortable. These procedures are a sue for healing and valuable information r	d ones heal, to help diagnose, y include debridement, ags, removal of suspicious skin rapings, suturing, callus with a numbing spray, gel or all important to skin and wound
Medicare patients are responsible 20% copay that Medicare <u>does no</u> those who elect not to carry a sec	Il PPO's. We do not accept any HMO's Mae for the yearly deductible which begins enter the yearly deductible which begins enter the yearly deductible which begins enter the year of year o	each calendar year and for the the secondary insurance. For mes Medicare's explanation of
and thank you for returning it in	ing sent for your signature. Please follow a timely manner. We look forward to pe do our best to help them heal and have fa	erforming excellent, unmatched
Patient/ POA Name	Patient/ POA Signature	 Date