Partners in Family Medicine

Consent for treatment/Financial Authorization

1. I hereby voluntarily request, consent to and authorize the physician, his/her associates, assistants, or other practitioners to provide medical and/or minor surgical treatment, including, but not limited to diagnostic procedures, medication administration, physical examination and screening services, including drug/alcohol screening, as is deemed necessary and advisable. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examination and treatment which I have hereby authorized.

2. I authorize Partners In Family Medicine and its affiliates to release to any third party payer, or it's representative, including Medicare, BCBS, commercial health insurers, automobile no-fault insurers, health maintenance organizations, preferred provider organizations and managed care plans which may be responsible for payment in my case, or as required by law. Such information from my medical record as is necessary in order to receive reimbursement for any billings rendered relating to my treatment, including alcohol and drug abuse records protected under the regulations in 42 CFR, Part 2, if any, and social services records, if any, and psychological service records including communications by me to a social worker or psychologist. I also authorize Partners in Family Medicine and its affiliates to release to individuals or agencies which may provide services for my care such as information from my medical record as is necessary to provide those services. I also authorize release of information to any independent auditors or reviewers retained by any third party payer, private health insurers, or any employer providing health insurance benefits to me so that these independent auditors can analyze charges.

3. I further understand my treatment may require more than one date of service; therefore this consent shall carry full force and effect from the date of signature until I am discharged from treatment.

4. I hereby assign payment directly to Partners In family Medicine of the insurance benefits otherwise payable to me, but not to exceed the balance due to Partners in Family Medicine for charges for these services.

5. I assume full financial responsibility for payment of all services provided to me, including any portion of my bill that is not paid by insurance. I understand and agree it is my responsibility as an insured patient of Partners in Family Medicine to understand and know my benefits under my contract with my insurance company.

6. I understand the content and significance of this form, and my questions have been answered.

********NOTICE*******

If another person has a percutaneous, mucous membrane, or open wound exposure to my blood or other body fluids, Partners in Family Medicine may perform, but no limited to, the following tests: HIV, Hepatitis screens, and other blood born pathogen tests as needed, without additional consent.
Public Act No. 488 of 1988 of the State of Michigan states that an HIV test may be performed upon me without any additional consent if a health professional or employee has a percutaneous, mucous membrane, or open wound exposure to my blood or body fluids.

X _____

Signature of Patient/Patient Representative **Relationship** **Date** **Witness**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have received Partners in Family Medicine Notice of Privacy Practices.

X _____

Signature (Patient /Representative) **Relationship** **Date** **Witness**

PRINTED NAME OF PATIENT _____ **DATE OF BIRTH**_____