Legacy Family Medicine, P.C.

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 minor surgical treatment, including but not limited to diagnostic procedures, x-rays, 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 the results of examination and treatment which I have hereby authorized.

2. I authorize Legacy Family Medicine, P.C. to release to any third party payer, or its representative, including Medicare, Medicaid, Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, workers' disability compensation insurers, employers, 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, social worker or psychologist. I also authorize Legacy Family Medicine, P.C. to release to individuals or agencies which may provide services for my care such 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 that 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 Legacy Family Medicine, P.C. of the insurance benefits otherwise payable to me but not to exceed the balance due to Legacy Family Medicine, P.C. 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, workers' disability compensation or social agencies.

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

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

If another person has percutaneous, mucous membrane, or open wound exposure to my blood or other body fluids, Legacy Family Medicine, P.C. may perform, but not limited to, the following tests: an HIV, hepatitis screens, and other blood borne pathogen tests, as needed, without any 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, mucus membranes, or open wound exposure to my blood or other body fluids.

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

Telephone consent obtained from:_____. Witness: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have been offered "The HIPAA Privacy Rule" explaining my health information privacy rights.

_____ _____

Signature (Patient/Patient Representative) Date

_____ _____

Printed (Patient/Patient Representative) Date

Patient Name:

Date of Birth: