Consent to Medical Treatment

Patient Name: _____ Age:_____

MR#: _____ Date: _____

Physician: _____

In consideration of medical services to be rendered to me (herein referred to as Patient) at Arbor Place Family Medicine P.C. (herein referred to as "Medical Practice"), Patient does hereby consent as follows:

1. Consent and Treatment Authorization

Patient (or the undersigned asking on behalf of Patient), who is requiring medical treatment, does hereby consent to the rendering of such care and treatment, which may include diagnostic procedures and such medical treatment and care as the Attending Physician or other physicians of the Medical Practice staff consider to be necessary and appropriate.

The consent to receive medical treatment includes, but is not limited to, examinations, diagnostic and therapeutic procedures, medications infusions, transfusions of blood and blood products, anesthesia, and any other medical treatment and services which Patient may require.

In the event that the Medical Practice should decide that blood specimens should be provided by the Patient for testing purposes in the interest of the safety of those with whom Patient may come in contact, Patient does hereby consent to such blood withdrawal and for the testing thereof, as well as to the release of test information where this is deemed medically appropriate or required by law.

2. Disclaimer of Guarantee

Patient hereby acknowledges that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury and of adverse results. Patient hereby acknowledges that no guarantees have been made to Patient or those acting for Patient as the results of procedures which Patient may undergo while a patient of Medical Practice.

3. Acknowledgments of Patient

Patient understands that:

a) It is customary, absent emergency or extraordinary circumstances, that no substantial of invasive medical procedures be performed upon a patient unless and until the patient has had the opportunity to discuss these procedures with the physician or other health professional so that the patient may be informed of the contemplated procedures.

b) Each patient has the right to consent, or refuse to consent to any specific procedure or therapeutic course of treatment. If patient refuses to consent to the administration of blood or blood products, Medical Practice reserves the right to

decline to provide medical care if, in the opinion of the Attending Physician, the refusal of blood products poses a serious threat to Patient.

4. Patient Understanding of Consent

This Consent Form has been adequately and fully explained to Patient, and Patient, by his or her signature, indicates satisfaction as to an adequate understanding of this Consent and of its significance and that Patient is voluntarily executing the same.

5. Authorization for Release of Medical Information

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities.

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information to other physicians for continuity of care issues.

6. Assignment of Insurance Benefits

For value received, I hereby irrevocably transfer, assign and set over to Medical Practice all insurance benefits of every kind and description, which benefits would be payable directly to me except for this assignment, and not to exceed Medical Practice's regular charges for the medical care given to me. Medical Practice reserves the right not to accept assignment of such benefits at its discretion.

7. Guarantee of Account

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility of all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to payment of those fees and charges not directly reimbursed to Arbor Place Family Medicine P.C. by any insurance policy, self-insurance program or other benefit plan.

I understand and acknowledge that it is my sole responsibility to obtain any required referral number prior to my visit. If I do not obtain such number, I will be responsible for all charges related to services rendered on my behalf.

I hereby authorize Arbor Place Family Medicine P.C. to provide such information as may be required by State or Federal agencies, and for and in consideration of the services rendered to patient, we, the undersigned, jointly or severally, promise to pay to Arbor Place Family Medicine P.C. the full amount of charged for such services, on demand, or by such future dates as may be determined by Arbor Place Family Medicine P.C. I understand that my bill will be due and payable in full on or before such date. I understand that, in the event account is not paid in full by such date, there will be added to my balance a Late Charge of one and one half percent (1 1/2%) per month on the outstanding unpaid balance. I understand that the application of the Late Charge will begin on the 61st day after the date of service, regardless of the status of any

insurance claims. I further understand that, should it become necessary to collect my debt through an attorney at law or a collection agency, that late charges will continue to accuse until the debt is paid in full.

8. Validity of Consent

This consent is valid during the entire term of my association with Arbor Place Family Medicine P.C. and may be relied upon by Arbor Place Family Medicine P.C. unless, and until, revoked by Patient, in writing.

WITNESS:_____

DATE/TIME:_____

PERSON GIVING CONSENT:

_____

DATE/TIME:_____

PERSON GIVING CONSENT (PRINT NAME):

_____

RELATIONSHIP TO PATIENT IF NOT THE PATIENT:

_____

PATIENT UNABLE TO SIGN BECAUSE:

_____