GROSSE ILE URGENT CARE

General Consent to Treatment

Name of Patient: _____ Date of Birth: _____/_____/_____

Consent to Grosse Ile Urgent Care (GIUC):

I request and authorize the type of services from ***GIUC*** as my physician, his assistants or designees (collectively called the "the Physician") advise. These include routine diagnostic, radiology and laboratory procedures, routine therapeutic procedures, routine drugs, and routine medical care. I understand that in emergencies it may be advisable to expand or deviate from the services listed here in order to preserve my life or health. I consent to these expanded services and procedures. I understand that medical personnel care for me according to the physician's instructions.

Consent to Testing and Disposal of Bodily Fluids and Tissue:

I understand that ***GIUC*** may perform non-diagnostic laboratory tests upon specimens of my blood, urine, and other bodily fluids/tissues for diagnostic purposes, and ***GIUC*** may dispose of these specimens as it chooses.

Release of Information:

I authorize the clinic to release all information from my entire medical record, including (Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS) and AIDS Related Complex (ARC), substance abuse treatment protected by 42 Code of Federal Regulations Part 2, psychological and social services including communications made by me to a psychologist or social worker) to:

any third party payer or insurance company (including Medicare, Medicaid, maternal and infant health, BCBS, commercial health insurers, automobile no-fault insurers, workers' disability compensation insurers, HMOs, PPOs, and managed care plans) which are responsible in whole or in part for paying my medical bill so that ***GIUC*** may be paid for its services

any health care facility or physician to which I am referred or transferred for continuity of care, and

any independent auditors or reviewer retained by any third party payer, private health insurer or any employer providing health insurance benefits to me so that these independent auditors can analyze ***GIUC*** charges

This release authorization shall be effective only so long as is necessary to accomplish the purpose for which it is given. With respect to substance abuse information (if any), this consent may be revoked at any earlier time unless ***GIUC*** has already released information in reliance upon it. I also agree that information in my record may be used for ***GIUC*** quality review purposes.

Personal Valuables:

I understand that it is my responsibility to take care of my personal belongings, including valuables like money, credit cards etc.***GIUC*** holds no responsibility for any lost or damaged personal valuables.

No Guarantees or Assurances:

GIUC has made no guarantees or assurances about the results of my clinic visit. I understand that a patient will receive the usual and ordinary care rendered in this community, and that no other contract, written or implied, is made.

Payment Provisions

I understand that, except in limited circumstances, separate billings will be issued for services of ***GIUC*** and services of physicians, and that neither charges are included in the billings of the order.

I request payment on my/the patient's behalf of all health care benefits for services provided by ***GIUC*** and by physicians for whom ***GIUC*** is authorized to bill.

I assign and transfer to ***GIUC*** health care benefits applicable to my/the patient's care. I authorize and direct that all such health care benefits be paid directly to ***GIUC***.

I agree personally to pay for ***GIUC*** or physician charges and services rendered, that are not covered by or collected by my applicable health care benefit program, including my deductibles and coinsurance amounts, etc.

I understand that I'll be billed directly for services I received at ***GIUC***, if my insurance carrier is unable to pay within 30 day period. Interest on unpaid balances will accrue at 1.5% on a monthly basis. I am ultimately responsible for all my medical bills.

I agree to pay account with ***GIUC*** in the event ***GIUC*** deems my account overdue. I agree to pay all cost of collection, including but not limited to court cost, interest and reasonable attorney fees.

I certify that I have read this form, that I understand it and consent to it. I also understand that by signing this form once it applies for today and all future treatments, unless it is specifically terminated/revoked by me. If the signer is not the patient, the signer certifies that he is the patient's duly authorized representative.

X: _____ DATE:_____/_____/_____ WITNESS: _____

Signature of Patient, or parent (if patient is a minor), or guardian (if patient is legally incompetent) (Office personnel)

In consideration of ***GIUC*** and professional services provided or to be provided to the patient, I guarantee payment of any ***GIUC*** or physician charges which are not covered by or collected from any applicable health care benefit program.

Human Immunodeficiency Virus (HIV) Testing

I was informed that ***GIUC*** may perform a test for HIV and other blood-borne diseases upon me without my written consent, as permitted by law, if a health professional or employee at ***GIUC***, or an emergency first responder, has a pericutaneous, mucus membrane, or open wound exposure to my blood or other body fluids.

Submit the completed form by email to **grosseile@downriverclinics.com**