Michigan Family Physicians

CONSENT FORM

FULL NAME: DATE OF BIRTH:

1. CONSENT: I consent to medical care including routine procedures, examinations, tests, immunizations, local anesthesia and other treatment by Dr. Kenneth Colton and his/her assistants, associates or a consultant as is necessary in their judgment. I consent to the testing and disposal of specimens of my blood, urine and other bodily fluids, tissues and products. I understand that an HIV (human-immuno deficiency virus) test may be done upon me without further consent if a doctor, health professional or employee sustains a percutaneous, mucous membrane or open wound exposure to my blood or other bodily fluid.

2. ADDITIONAL CONSENT FORMS: I understand that for certain procedures deemed necessary by my physicians(s), I will be required to sign a special consent form. Further, if I do not fully understand a procedure or its risks, consequences and alternative methods of treatment, I have the right to question the appropriate health care professionals.

3. RELEASE OF INFORMATION: I authorize the physicians to release to any party responsible for payment for my care, such information from my medical records as is required in order for the physician to obtain payment and to any participant in audits of such payments. This authorization to release information for the purposes of payment, includes all records, including those records protected under the regulation in Code 42 of the Federal Regulations, Part 2 and Michigan Public Act 488 of 1988 of Alcohol and Drug Abuse and/or Treatment, records of psychological services and records of social services including communications made by the patient to a physician, social work or psychologist as well as treatment for serious communicable diseases including Acquired Immune Deficiency Syndrome (AIDS). HIV infection, AIDS Related Complex and Hepatitis.

4. INSURANCE: I authorize the doctor and staff to review my insurance coverage with my insurance company. I certify that any and all information provided by me in furtherance of my application for health care benefits are true. I authorize payment of insurance benefits to me made directly to the doctor. I agree to pay in full any and all charges not covered by insurance or other benefits.

5. NO GUARANTEE: I understand that the practice of medicine is not an exact science and that the doctors or assistants have made no guarantees or promises to me as a result of treatments or examinations.

I have read this form. It has been fully explained to me, and all of my questions about it have been answered. I understand its contents.

Patient Signature: _____ Date: _____
(Or Guardian's)

Witness Signature: _____ Date: _____