MOUNT PLEASANT
MEDICAL ASSOCIATES

CONSENT FOR TREATMENT

4639 EAST PICKARD STREET, SUITE B, MT. PLEASANT, MI 48858 PH# 989-817-4300

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PATIENT NAME: _____ Date of Birth: _____

CONSENT FOR CARE AND TREATMENT: I request and consent to such care and medical treatment as deemed necessary by my physicians. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees or promises have been made to me regarding the results of any care or treatment.

TESTING FOR PRESENCE OF HUMAN IMMUNODEFICIENCY VIIRAL SYNDROME (HIV/AIDS) AND HEPATITIS: I understand that, in the event a physician, nurse, or other health care provider is exposed to my blood or body fluids, my blood may need to be tested without my consent for the presence of an infectious disease, such as hepatitis or human immuno deficiency viral syndrome (HIV). The results of the test will only be released to the exposed person and no one else unless required or authorized by the legal system. If the results indicate the patient is infected, Mount Pleasant Medical Associates will notify the patient and offer to provide appropriate counseling.

CONSENT TO USE AND DISCLOSURE OF MY MEDICAL INFORMATION: I authorize MPMA and my physician(s) to use and disclose medical information about me for the purposes of treatment, payment and hospital operations. I understand that my medical information may include information that may be related to psychiatric conditions, sexually transmitted disease such as HIV and AIDS, and treatment of drug and alcohol conditions. I understand that my consent to uses and disclosures of my health information may only be revoked in writing, but my authorization to disclose information regarding treatment for drug and alcohol conditions is effective only as long as reasonably necessary to serve the stated purposes for which it is given.

FINANCIAL AGREEMENT: I assign and authorize direct payment of all health care benefits and other forms of payment of any kind which relate to the care provided to me by MPMA and my physician(s) for application to my bill. I assume full financial responsibility for payment of all expenses associated with my care and treatment.

CHAMPUS AUTHORIZATION (if applicable): I request that payment of authorized benefits be made either to me or on my behalf to MPMA for any services furnished to me by MPMA, including physician services. I authorize any holder of medical information about me to release to CHAMPUS and its agents any information needed to determine these benefits or the benefits payable for related services.

MEDICARE CERTIFICATION (if applicable): I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

The undersigned certifies that he/she has read the foregoing, and is the patient, or duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

_____ _____

Signature of Patient or Representative Date of Signing

_____ _____

Print Name of Signer Relationship of Signer to Patient

_____

Witness