Petoskey Surgeons, P.C. --- Patient Consent and Release Form

CONSENT FOR TREATMENT: By signing this form, I consent and authorize my health care provider, assistants or designees to examine and treat me. I understand that this could include medical treatment, lab tests, education, or other diagnostic procedures. I understand that my provider is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment. I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of examination or treatment in this office. I authorize Petoskey Surgeons, PC to access prescriptive claims history through an electronic prescription system as may be required for ongoing care and medication management.

RELEASE OF INFORMATION: I hereby authorize Petoskey Surgeons, P.C. to release to all insurance companies, third party payors (and to my Employers if worker's compensation), and utilization review organizations, any medical or other necessary information for the purpose of obtaining authorization for medical services and for payment of my medical bills. I have received a copy of the office Financial Policy. I also authorize the release of information necessary for my continuing medical care.

ASSIGNMENT OF BENEFITS: I authorize all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, BCBSM, and other government sponsored programs, private insurance, and any other health plans to Petoskey Surgeons, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

OBTAIN AND TRANSFER INFORMATION: I authorize Petoskey Surgeons, P.C. to obtain and/or transfer clinical information about me to or from any other healthcare provider or health care agency including but not limited to physicians, hospitals, nursing homes, home care agencies and public health departments, in order to enhance the continuity of my care. I understand and agree that the information transfer will occur by means deemed most appropriate to the circumstances by Petoskey Surgeons, P.C. including photocopy, electronic file transfer, facsimile, and computerized information systems. I also understand that Petoskey Surgeons, P.C. may provide information to third parties for quality control and research studies.

RELEASE FOR STUDENTS OR TRAINEES: I understand that Petoskey Surgeons, P.C. provides training and orientation programs for students and employees. The training requires observation and supervised participation in the care of patients. I consent to the presence and supervised participation of such students and employees as deemed necessary by my physician.

RELEASE OF MEDICAL RECORDS FOR RESEARCH: State Law requires us to inform you that your medical records may be released for research purposes unless you object. Occasionally, a physician receives a request from medical or scientific researchers for a copy of our patient records in order to conduct a research study. We evaluate these requests to ensure that the release of patient records is necessary to accomplish the research purpose. The researcher cannot use patient names or other identifying characteristics when reporting any results of their research. Initial here _____ if you do not authorize this release. You may revoke this agreement at any time by notifying us in writing.

DISCLOSURE OF PRESENCE: I understand that during my visit my friends, family, employers or others may call to inquire about my presence at Petoskey Surgeons, P.C.

I authorize you to disclose information about my presence at this office to the following people:

_____

I hereby authorize my physician to verbally communicate regarding my care with:

_____
Family Member/Caregiver Name Relationship

I authorize the staff at Petoskey Surgeons, P.C. to leave messages on my phone at (____)____-_____.

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_____ _____
Signature of patient, parent or guardian Date of Birth

_____ _____
Please print patient name Date