

DATE:	ACCOUNT:	PATIENT NAME:	DOB:
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CONSENT TO TREATMENT AND RELEASE OF INFORMATION

Consent to Treatment: I authorize and consent to medical, diagnostic, therapeutic, and minor surgical procedures and treatment by the physicians, physician assistants, nurse practitioners and other staff of Clarkston Medical Group, P.C. and its affiliated covered entities Associated Radiologists of Clarkston, PLC and Clarkston Urgent Care, PLC (collectively and individually, as applicable, "CMG") for myself or for my minor child or ward listed as Patient on this document. I understand the risks of the medical treatment and procedures and that the practice of medicine is not an exact science, and no guarantees, promises or assurances have been made concerning the outcome of such procedures and treatment. I understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures.

- I have an Advance Directive (living will, health care surrogate declaration, durable power of attorney) and request that it govern my care if I am unable to make decisions. I understand that it is my responsibility to provide CMG with a copy of my Advance Directive.
 - Advance Directives attached
 - Advance Directives not attached
 - I do not have an Advance Directive

I understand that if any agent or employee of CMG sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound or other significant exposure to my blood or other bodily fluids, I may be tested for HIV (the virus that causes AIDS), Hepatitis B, Hepatitis C, and/or RPR; and I consent to such tests. The results of any tests will be treated confidentially.

Release of Protected Health Information ("PHI"): I authorize CMG to release the PHI such as medical records and information about the appointments, tests, treatments, and/or other information pertinent to the healthcare or payment for the healthcare provided at CMG to:

1. Any insurance carrier, workman's compensation or agency (social welfare, governmental) responsible for all or any part of CMG's charges and/or professional fees.
2. Any physician or health care facility as may be needed for any treatment and care.
3. Any Peer Review Organization responsible for reviewing medical care.
4. An employer or any other entity authorized to approve or disapprove disability benefits.
5. The following individual / organization:

Name: _____ Relationship: _____ Date of Birth: _____

Address: _____

Name: _____ Relationship: _____ Date of Birth: _____

Address: _____

The release of PHI to the individuals / organizations listed above will not include the following information unless the appropriate box is checked:

- Any records of treatment for drug and/or alcohol dependency or abuse.
- Any record of mental health treatment, psychological services, social services, including communications made to a social worker or psychologist.
- Any record of testing, care, treatment or research pertaining to HIV, AIDS or other communicable diseases.

Clarkston Medical Group, P.C., Associated Radiologists of Clarkston, PLC and Clarkston Urgent Care, PLC are affiliated business entities, and have designated themselves as an "affiliated covered entity" for purposes of HIPAA compliance. Because of such designation, PHI may be used and disclosed within CMG in the same way as it could be disclosed within one single entity.

I understand that authorizing the disclosure of the PHI is voluntary and that it covers multiple requests for such information, and that this authorization authorizes CMG to respond to such requests. I also understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet the eligibility or enrollment criteria.

By signing this form, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by federal or state privacy rules. I further understand that I may request a copy of this signed authorization.

Restrictions, Confidential Communications: You may request that CMG restrict how your PHI is used or disclosed, but CMG is not required to agree to the restrictions. You may ask CMG to send or transmit PHI or contact you or your designee at alternative locations or by alternative means.

Address where CMG should send your correspondence if other than your home: _____

Should CMG remind you about your appointments by sending postcards? YES ___ NO ___

If you do not want CMG to call or leave messages on your home telephone number about your appointments, diagnostic test or lab results, or other PH, list the telephone number where CMG should call and/or leave messages with this information: _____

Procurement of Information: I authorize CMG to obtain my PHI and any medical records from other physicians, hospitals or health care facilities as needed for my medical care or the medical care of the person for whom I am authorized to sign.

Notice of Privacy Practices. I have reviewed CMG's Notice of Privacy Practices that contains more detailed information about how CMG may use and disclose PHI. CMG may, from time to time, change its privacy practices.

The consents and authorizations given above may be revoked at any time in writing except to the extent that action has already been taken in reliance thereon. If not previously revoked, the consents given above shall expire on the date which is ten (10) years from the date of your last visit to CMG.

Print Name

Signature of Patient or Next of Kin, Legal Agent/Guardian and Relationship to Patient

Signature of Witness

Date

CLARKSTON MEDICAL GROUP, P.C.
5701 Bow Pointe Dr., Suite 100,
Clarkston, MI 48346

ASSOCIATED RADIOLOGISTS OF CLARKSTON, PLC
5701 Bow Pointe Dr., Suite 110, Clarkston, MI 48346
7210 North Main Street Suite 211, Clarkston, MI 48346

CLARKSTON URGENT CARE, PLC
5701 Bow Pointe Dr., Suite 120,
Clarkston, MI 48346

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PERSONS INVOLVED IN PATIENT'S HEALTH CARE

I authorize the person(s) listed below to accompany the Patient and be present during Patient's medical examinations, treatment and/or procedures:

Name: _____ Relationship: _____ Date of Birth: _____

Address: _____

Name: _____ Relationship: _____ Date of Birth: _____

Address: _____

Name: _____ Relationship: _____ Date of Birth: _____

Address: _____

FINANCIAL RESPONSIBILITY

Assignment of Benefits: I hereby assign to CMG all rights to insurance payment for professional services provided by it. I agree this assignment is primary to any assignment given after this date including any cost relative to attorney fees. This assignment will remain in effect until it is revoked in writing by Patient or a person authorized to revoke it on Patient's behalf. A photocopy of this assignment is to be considered as valid as the original.

Guarantee of Payment: I agree to be responsible to CMG for charges resulting from services rendered that are not covered by insurance or other third party payment. I agree all bills are due in full at the time of service. I agree to pay \$5.00 processing fee if I do not pay the applicable co-pay or deductible at the time of my office visit. Should I fail to honor these obligations, I agree to pay any collection costs and / or attorney fees resulting from the collection of my accounts.

Certification: I certify that I have read or had this form read and/or explained to me, that I fully understand the consents and authorizations given above, that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily, and that I am the Patient listed in this document or I am duly authorized by the Patient listed in this document to provide the consents and authorizations described herein and to sign this document.

References to "I", "me", "my", "you" and "your" in this document refer to the person listed in this document as the Patient, even though a next of kin, legal agent or guardian signs this document on behalf of or for the Patient. If this document is signed by next of kin, legal agent or guardian, such person represents and warrants to CMG that he or she has the necessary power and authority to execute this document and to make decisions regarding the health care of the person listed in this document as the Patient, and he or she agrees to indemnify, defend and hold CMG harmless in connection with that his or her breach of this representation and warranty. CMG may and shall treat, rely and enforce all statements made by Patient's next of kin, legal agent or guardian to the fullest extent permitted by law.

Print Name

Signature of Patient or Next of Kin, Legal Agent/Guardian and Relationship to Patient

Signature of Witness

Date

If Patient is unable to sign, secure consent of Next of Kin or Legal Agent and indicate reason:

- Minor
- Disoriented
- Incompetent
- Medically Unstable