

Patient Consent For Treatment

Patient Name _____ PRK# (Office Use) _____

Authorization for Treatment

I hereby authorize the performance of any examinations, treatments procedures or operations, including, but not limited to, any anesthetic and the taking of X-rays, which in the judgment of the admitting physician or any consulting physician may be advisable. Without limitation, the foregoing extends to the staff of Borgess Medical Center. I understand and agree that, pursuant to the Michigan Department of Public Health Code, Borgess Medical Center may perform an HIV or AIDS test without my written consent if such test is performed after any physician, nurse, other health professional or health facility employee sustains a percutaneous, mucous membrane or open wound exposure to my blood or other body fluids.

I further authorize the physician to retain the services of assistants or designees as is necessary in his or her judgment, whose charges for services are separate and distinct from those of the attending physician.

Authorization to Pay Insurance Benefits

I hereby authorize payment directly to Borgess Medical Center of any insurance benefits or other payments by third parties otherwise payable to me, but not to exceed the Medical Center's customary charges for this period of service. I understand that I am financially responsible to the Medical Center for charges not covered by insurance.

Release of Medical Information

I hereby authorize Borgess Medical Center to furnish any and all information required to establish my claim for benefits with my insurance company or any agency from which I claim benefits in payment of my bill from Borgess Medical Center. This authorization may include information about communicable diseases, including HIV and AIDS-related complex, substance abuse, mental health and social services information. I further authorize the release of all or any portion of my record as deemed reasonable for the delivery of coordination of my care to other hospitals, physicians, home health providers, insurance companies or other health care facilities that may provide for my continuing care.

I UNDERSTAND THAT THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM THE TIME OF MY SIGNATURE AS INDICATED BELOW.

Date _____ Signed _____
(If signator is not the patient, please indicate relationship)

Witness _____