South Lyon Family Docs

Patient Demographics:

Last Name: _____ First Name: _____

Date of Birth: _____ Gender: M / F / Transgender / Non-Binary / Other

Address: _____

Phone: _____ Email: _____

Emergency Contact:

Name: _____

Phone: _____

Relation: _____

Emergency Contact:

Name: _____

Phone: _____

Relation: _____

Assignment and Release:

I hereby authorize and direct payment of my insurance benefits for myself or my dependents (otherwise payable to me) to **South Lyon Family Docs**. I understand that I am financially responsible to the medical group for charges not covered by this authorization. I authorize South Lyon Family Docs to use and disclose my protected health information as necessary to contact my insurance company for obtaining payment, authorization, and determination of insurance benefits payable for related services.

Signature: _____ Date: _____

Release of Patient Information:

I give permission to **South Lyon Family Docs** to share my health information, including medical and billing records, with the person(s) listed below for care, payment, or other stated purposes. I may cancel this permission in writing at any time, unless the information has already been shared. I understand that once shared, the information may no longer be protected by federal privacy laws. This permission will end one (1) year from the date I sign this form unless I choose a shorter time. **YES___** **NO___**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Printed Name of Signer: _____

South Lyon Family Docs

GENERAL CONSENT TO TREATMENT

Patient Name: _____

Date of Birth: _____ **Medical Record #** _____

1. **Consent:** I request and authorize medical or surgical treatment as may be deemed necessary and appropriate by the physician and his/her designees and assistants participating in my care. This care may include: diagnostic; radiology and laboratory procedures; blood transfusions; anesthesia; therapeutic procedures; drugs; and medical; nursing and hospital care.
2. **Release of Information:** I authorize South Lyon Family Docs to release pertinent information and/or copies of medical records for treatment, payment, or health care operations purposes. I understand such information may include Human Immunodeficiency Virus (HIV), AIDS related complex (ARC), Acquired Immunodeficiency Syndrome (AIDS), Hepatitis, substance abuse, psychiatric/psychological services records, and social work records, if any.
3. **Human Immunodeficiency Virus (HIV) and Hepatitis B/C Testing:** I understand and agree that, in accordance with State law, an HIV, HBV or HCV test may be performed upon me in the event a health care worker sustains a significant exposure to my blood or body fluids. The results of any test will be treated confidentially.
4. **Testing and Disposal of Specimens and Tissues:** I authorize South Lyon Family Docs to retain, preserve or use for research scientific or teaching purposes, or to dispose of any specimen remaining after completion of a clinical procedure or treatment.
5. **Valuables:** I release South Lyon Family Docs from responsibility of all personal articles which I have with me during the time I am a patient at the office. I understand that the office is not responsible for clothing, eyeglasses, dentures, jewelry, money or other personal articles of value kept in my possession or in the office.
6. **Payment:** I assign and authorize payment from my insurance company directly to South Lyon Family Docs for any and all services rendered. I agree to pay, at the time of discharge or on an interim basis (agreed upon by the office), all charges not covered by my insurance company. I understand that it is my primary responsibility to pay South Lyon Family Docs all charges for services rendered irrespective of any of any disputes or disagreements between myself and insurance companies.
7. **No Guarantees:** I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have hereby authorized.
8. **Minors:** A patient under 18 years of age must have authorization of treatment from a parent or legal guardian. Minors with decision-making capacity have the right to participate in discussions regarding their care, and to answers to their questions about their condition and treatment.
9. **HIPAA:** Copy of our HIPAA agreement made available to the patient.

I have read this form or it has been read to me and I am satisfied that I understand its contents. I further understand that this consent will be deemed continuing and I am free to withdraw my consent at any time.

_____

Date *Signature of patient/parent (if patient is a minor/legal guardian) relative (if patient is unable to consent)*

_____

Signature of Witness *Indicate relationship*

South Lyon Family Docs

PATIENT AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

I _____, hereby authorize

Person/Organization to Release Information _____

Address _____

Phone/Fax Number _____

to release information contained in my patient medical record INCLUDING alcohol and drug abuse records protected under the regulations of 42 Code of Federal Regulations, Part 2, if any, psychiatric, psychological service records, if any, and social work records. If any, including communications made by me to a social workers psychiatrist/psychologist, and any information regarding communicable diseases and serious communicable diseases and infections as defined by Michigan Department of Public Health rule which can include venereal disease, tuberculosis, HIV, AIDS or ARC, if any, to individuals or organizations listed below under the conditions listed below:

1. Person to Whom Disclosure is to be made: **SOUTH LYON FAMILY DOCS**

   Address: **26006 Pontiac Trail, South Lyon MI 48178** Fax Number: **248-437-5694**

2. DO NOT DISCLOSE THE FOLLOWING (Check all that apply) ☐ Alcohol and/or Drug Abuse Information
   ☐ HIV, AIDS, or ARC Information ☐ Psychiatric Information

3. _____
   SPECIFIC AND MEANINGFUL DESCRIPTION OF THE INFORMATION TO BE DISCLOSED – INCLUDE DATES

4. The purpose and need for such disclosure:
   ☐ BILLING INFORMATION/INSURANCE ☐ CONTINUATION OF TREATMENT/FOLLOW-UP
   ☐ OTHER (specify) _____ ☐ PER THE REQUEST OF THE INDIVIDUAL

You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire six (6) months from the date of signing.

I understand that my health information that is disclosed under this Authorization may be subject to redisclosure by the recipient and the privacy of my health information will no longer be protected by the law.

Signature(s): _____ Date: _____
Patient

_____ _____ _____
Driver's License Number Date of Birth of Patient Last four digits of SSN

_____ Date: _____
Parent/Guardian /Legal Representative

_____
Driver's License Number

Legal Representative Paperwork: ☐ Proof of Guardianship ☐ Durable Power of Attorney for Healthcare
(attach a copy) ☐ Letters of Authority

Witness Signature: _____ Date: _____