Barbara Ann Center For Family Medicine
15565 Northland Dr., Suite 108E
Southfield, MI 48075
Tel. 248-905-5470
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Patient Consent Form

Print Name: ____ MRN#: _____________
(Last) (First) (MI)

1. **CONSENT:** I consent to medical care including routine procedures, examinations, test, immunizations, regional and local anesthesia and other treatment by staff and practitioners of Barbara Ann Center For Family Medicine and his/her assistants, associates as is necessary in their judgment. I realize that the clinic is sometimes used as a teaching facility and I consent to medical care being performed by residents, physician extenders or medical support staff. I consent to the testing and disposal of specimens of my blood, urine and other bodily fluids, tissues and products. I understand that HIV (human-immuno deficiency virus) test may be done upon me without my further consent if a doctor, health professional or employee sustains a precutaneous, mucous membrane or open wound to my blood or bodily fluids.
2. **ADDITIONAL CONSENT FORMS**: I understand that for certain procedures deemed necessary by my physician(s), I will be required to sign a special consent form. Further, if I do not fully understand a procedure or its risks, consequences and alternative methods of treatment. I have the right to question the appropriate health care professionals.
3. **RELEASE OF INFORMATION:** The clinic and each provider who treats me may release to whomever is potentially responsible for payment and/or subsequent treatment, information and/or financial records as necessary or desirable for my care or for the clinic and/or provider to obtain payment for audits of such payments. This authorization includes all records, including records of mental health and substance abuse services, treatment for AIDS, HIV infection, AIDS Related Complex, and Hepatitis.
4. **INSURANCE:** I authorize the doctor and the staff to review my insurance coverage with my insurance company. I certify that any and all information provided by me is furtherance of my application for health care benefits are true. I authorize payment of insurance benefits to me made directly to the doctor. I agree to pay in full any and all charges not covered by insurance or other benefits.
5. **NO GUARANTEES:** I understand the practice of medicine is not an exact science and the no guarantees or promises have been made to me as a result of treatments or examinations by the doctors or assistants.

This authorization for release shall be effective for five (5) years from the date of this consent unless a revocation of authorization in writing is filled at the clinic to terminate this authorization. Such revocation is prospective and not retrospective, and only applies to release of information for nothing other than to obtain payment.

I HAVE READ THIS FORM AND I UNDERSTAND ITS CONTENTS.

Patients Signature: ____ Date _______________

Patient's Guardian Signature: _____________________________________ Date _______________

Witness ____ Date _______________