Family and Pediatric Medicine of Grand Rapids

4130 Breton Rd SE, Suite B

Grand Rapids, MI, 49512

Phone 616-281-0093 / Fax 616-281-0580

General Consent for Treatment and Release Information

1. **Consent for General Treatment** – I request and authorize healthcare services to be provided by Family and Pediatric Medicine of Grand Rapids
2. **No Representations or Guarantees** – I am aware that the practice of medicine is not an exact science and I acknowledge that no oral or written representations or guarantees have been made to me as to the results of any diagnosis, treatment and medical care that I (or patient) may receive as a patient.
3. **Release of Information** – I authorize Family and Pediatric Medicine of Grand Rapids to release copies of my medical records, including information from prior treating and/or referring physicians and hospitals and other healthcare providers or diagnostic centers, x-rays, reports and information about substance abuse treatment, mental illness, HIV infection, acquired immunodeficiency syndrome, acquired immunodeficiency syndrome related complex, venereal disease or tuberculosis
    a. To any governmental agency, billing services, insurance company, auditing agency, engaged by Family and Pediatric Medicine of Grand Rapids or a third-party payer, employer, or physician for the purpose of processing any claims for benefits.
    b. To any physician or health care facility to which I (the patient) may be referred to for the purpose of continuing patient care. This release is subject to written revocation at any time except to the extent that action has been taken.
4. **Insurance Coverage** – I authorize Family and Pediatric Medicine of Grand Rapids to file and pursue a claim for payment of my charges with my insurance carrier as specified now or requested later. I further assign insurance benefits payable to me to Family and Pediatric Medicine of Grand Rapids. I understand that I am financially responsible for any balance not covered by insurance.
5. **Personal Property** – I agree and acknowledge that Family and Pediatric Medicine of Grand Rapids has no responsibility for loss of clothing, money, valuables, glasses or any other personal items of mine and understand that arrangements should be made by me to safeguard items during my stay.
6. **Notice of Privacy Practices** – I acknowledge that I have received the Notice of Privacy Practices. I hereby certify that I have read this form or it was read to me; that this form was explained to me at the date and time below written and that I fully understand the contents of this form.

If a patient is **under 18 years of age** or **otherwise unable to consent**, the following must be completed:

I, _____ certify that I am the parent/guardian of the patient; and that
Print Name of Parent or Responsible Party
the patient is unable to sign the consent because they are a minor.

_____/___/____ _____/___/____
Signature of Parent or Responsible Party Date **Signature** of Witness Date

♦ IF 18 YEARS OR OLDER:

_____/___/____ _____/___/____
Signature of Patient Date **Signature** of Witness Date