Upper Great Lakes Family Health Center

PATIENT CONSENT FOR EXAMINATION/TREATMENT & RELEASE OF INFORMATION

1. AGREEMENT FOR EXAMINATION AND/OR TREATMENT: I hereby agree and consent to be examined and treated by a provider at Upper Great Lakes Family Health Center. I understand I have the right to participate in decisions involving my health care. In the event I may be harboring an infectious disease such as Hepatitis B or Human Immunodeficiency Virus (HIV) which could endanger the health of individuals accidentally exposed to my blood or body fluids, I do hereby voluntarily consent to preventative screenings, diagnostic/procedures, tests and care provided by Upper Great Lakes Family Health Center. I further understand that any test results will become part of my health record, and as such its confidentiality is protected by Federal Law.

2. FOR PATIENTS RECEIVING SERVICES PROVIDED BY DENTAL STAFF UNDER THE MICHIGAN PUBLIC DENTAL PREVENTION PROGRAM: I understand the following preventative services may be provided by a dental hygienist: Fluoride Varnish, Pit and Fissure Sealants, Prophylaxis, Nutritional Counseling, Oral Health Education, Topical Fluoride, Assessments, Tobacco Cessation and Periodontal Maintenance. I consent to those deemed necessary as agreed upon between myself and the health care professional.

3. AUTHORIZATION TO RELEASE INFORMATION: I understand that Upper Great Lakes Family Health Center participates in an "organized health care arrangement" with UP Health System. Upper Great Lakes Family Health Centers shall provide continuity of care for patients utilizing services from all organizations.

I hereby authorize release of clinic health records relevant to examination and/or treatment including laboratory reports and x-rays, to the consulting and/or referring physician or agency, to the source(s) of continuing care, including Upper Great Lakes Family Health Center providers, facilities and Clinics. I also authorize the release of these records to any insurance carrier, government agency or unit, or third party payor, in any way involved in the payment of all or any part of the clinic bill.

4. PAYMENT AGREEMENT: I hereby assign payment directly to Upper Great Lakes Family Health Center, of authorized benefits to be made on my behalf not to exceed the balance due to the provider's regular charges. I understand that I am financially responsible to Upper Great Lakes Family Health Center for charges not covered by this authorization under the provisions of the Federal Truth in Lending Law, 7169. I understand that Upper Great Lakes Family Health Center may be ordering services or obtaining specimens that may be sent to a 3rd party for processing and I may receive bills from them directly.

This consent is valid for one year from date of signature unless I notify Upper Great Lakes Family Health Center in writing of my withdrawal.

By Signing below I represent and warrant that I have presented Upper Great Lakes Family Health Center with any and all potential insurances by which my beneficiaries/I are/am covered.

I hereby release Upper Great Lakes Family Health Center from all legal responsibility or liability that may arise from the acts that I have authorized above.

_____ Print Patient Name _____ Date	_____ Patient /Representative Signature _____ Date	_____ Witness Signature _____ Date

Witness for Telephone Authorization: _____