Patient Consent Form

Please read this form carefully and sign where indicated. This consent is required to render medical services and to obtain payments from your insurance carrier(s). Please ask our staff member if you have any questions regarding the contents of this form

PERMISSION TO EXAMINE AND TREAT:
I hereby give my permission to Macomb Physicians Group, PLLC, its physicians and staff to obtain medical history, carry out medical examination, and/or procedures needed to make a diagnosis and offer medical treatment.

REFUSAL OF MEDICAL TREATMENT:
I understand that I have a right to refuse any and all medical treatments and recommendations. I shall take full responsibility of my actions in case of refusal of treatment or not following medical recommendations.

FINANCIAL RESPONSIBILITY:
I understand that I am financially responsible for all the charges whether or not they are covered by my insurance carrier(s). I also understand that some insurance do not cover routine examinations, annual physicals, school physicals and third party examinations. I agree to pay any co-payments, deductibles and/or services not covered by my insurance carrier on the date of service.

Macomb Physicians Group, PLLC will submit a claim to your insurance carrier(s) on your behalf, if correct insurance information is provided on the date of service. If we are unable to collect on your outstanding debt within a reasonable time (6 weeks or so), we shall hand over your account to a collection agency and dismiss you as a patient of our medical practice.

LABORATORY TESTS:
I authorize Macomb Physicians Group, PLLC to send my blood/urine etc. specimens to an outside laboratory for testing. I understand that I shall be financially responsible for payments of the laboratory services that are not covered by my insurance carrier(s). I understand that bills for unpaid laboratory services will come from the laboratory where my specimens were sent.

ASSIGNMENT OF BENEFITS:
I hereby assign, transfer, and set over Macomb Physicians Group, PLLC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. A photocopy of this document shall be considered as effective and valid as original. Medicare assignment of benefits will apply accordingly. This authorization shall remain valid until a written notice is given by me revoking said authorization.

AUTHORIZATION TO RELEASE MEDICAL-RELATED INFORMATION:
I authorize release of medical information needed to determine my medical reimbursement benefits. (Your insurance may request such information to prove that you were seen in the office. In Michigan, we are required to provide this information by law)

SUMMARY:
We may treat you
You may refuse treatment
You permit us to bill your insurance
Ultimately you are responsible for the payments
Laboratory tests go to outside facilities

Signature: _____ Date: _____
(Patient or Guardian)

Relationship to patient if you are a guardian: _____