Geriatric and Medical Specialists of Michigan, PLC

1. Consent to treatment

I _____, hereby voluntarily consent and authorize Dr. Schumacher, Dr. Rebecca Baumbach, Shawn Badal Nurse Practioner, Beth Schumacher, MSW and their associate Physicians, or other practitioners under their orders to attend to me and to provide medical treatment and care, including but not limited to, diagnostic procedures, X-rays and medications as is deemed necessary and advisable. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments and examinations in this facility.

_____ _____ _____

***Patient's Signature/**Legal Representative Date Signature of Witness

2. Agreement to Pay for Service

I understand that I am liable and responsible for any health insurance deductibles and coinsurance portions of my medical bill. I also understand that I am responsible for all services to be rendered to the patient whether signing as agent or as a patient. The undersigned certifies that (s)he has read the foregoing or that if it has been read to him/her, and that (s)he understands the same and consent thereto, and that (s)he is the patient or the duly authorized representative or agent of the patient to sign this form and consent thereto. I further understand that my treatment may require more than one date of billable service; therefore, this consent shall carry full force and effect from the date of signature until I am discharged from further outpatient treatment.

_____ _____ _____

***Patient's Signature**/Legal Representative Date Signature of Witness

3. Advance Directives

I understand that I have a right to provide this facility with advanced directives regarding medical treatment decisions, including the right to refuse unwanted medical treatment or ask that it be withdrawn. I currently ____do_____do not have any such directives formally written.

_____ _____ _____

***Patient's Signature**/Legal Representative Date Signature of Witness

4. HIPPA

This is an acknowledgement that I have been offered a copy of the HIPAA disclosure form.

***Patient's Signature**_____Date:_____

List the names of the person(s), if any, whom we may discuss you medical condition/care with.

_____ _____

Name Phone

_____ _____

Name Phone

PLEASE TURN PAGE OVER

Print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home:

_____

Indicate if you would like all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL" YES_____ NO_____

Print the telephone number where you would like to receive calls about your appointments, test results, or other health care related information if other than your home phone number:

_____-____-_____

Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? YES_____ NO_____

**Any test results will not be left in the form of a message regardless if they are "normal" or "abnormal".

Patients Signature_____Date_____

NO SHOW POLICY:

Our office makes appointments for you in good faith and it is important that you keep your appointments. However, if you find that you will not be able to keep your appointment we ask that you give the office **24 hours notice** so that we may schedule another patient in your appointment time. There is a **$25.00 charge** for appointments that are missed without proper notification, we understand that it is not always possible to give 24 hour notice, so please call as soon as possible before your appointment and we may be able to waive the fee for emergency reasons only. However if we do not receive a call before your appointment time we will not be able to waive fee. For patients with multiple no shows or same day cancellations, we reserve the right to terminate our patient-provider relationship.

Policy Update: As of 5/1/2015 we <u>may</u> reschedule your appointment if we are unable to confirm your appointment with you by noon the day before your appointment. We will start trying to contact you at least two days prior.

Please sign to acknowledge that you have been informed of this policy, failure to sign policy does not mean that the policy does not apply to you.

Patients Signature_____ Date_____

As a member of Geriatric and Medical Specialists, it is my statement that _____

has been informed of our No Show Policy but refuses to sign statement.

_____ Date_____

(Employee's Signature)