Northview Medical House Calls
1184 Cleaver Rd Suite 300
Caro, MI 48723

Patient Name:_____
(Please Print)

CONSENT FOR TREATMENT

I acknowledge and understand that, in presenting myself for treatment and continuing medical care with Northview Medical House Calls Practice (NVMHC) that I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the physician (and/or designated assistant) and carried out by members of the NVMHC Medical staff and personnel. Minors must be accompanied by a parent/legal guardian for medical care except when the minor is seeking specific services for which they are not required to obtain parental consent, accompaniment or guidance, as clearly expressed by State law.

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR PAYMENT

I authorize NVMHC to release medical information or copies from my medical record within a reasonable time frame to insurance companies, third party payers, or authorized agents; or claims review organizations in order to process a claim for
payment on my behalf. This information may be disseminated to any and all employer's insurance companies or their designees who may provide coverage for medical charges and to comply with the requirements of any Professional Review Organization. This authorization may be revoked in writing at any time.

PAYMENT AGREEMENT

I hereby assume full responsibility for and agree to pay all costs, charges, and expenses incurred by the patient, to NVMHC Plc. I understand and agree that this understanding constitutes a direct primary and personal undertaking by me and is not conditioned or contingent upon payment of any such costs, charges or expenses by any third party. And assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed waiver of the Provider's right to require payment directly from the undersigned. The Provider expressly reserves its right to require such payment. In the event that this obligation remains unpaid and requires referral for collection, the undersigned agrees to pay all costs of collection, including, but not limited to reasonable attorney's fees. If the undersigned is more than one person every obligation hereunder shall be joint and several.

All deductibles and co-pays are due at the time of service. We accept cash or checks. Our charges are usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates, unless we have a participating agreement with that company.

By signing below you acknowledge and consent to sections specifically indicated above: Consent for Treatment, Assignment of Benefits, Authorization to Disclose Medical Information for Payment and Payment agreement.

I understand and agree to the above statements.

X _____ **Date:**_____
Signature of Patient / Parent / Guardian

X _____ **Date:**_____
Witness

Ph: (989) 282-4003
Fax: (888)-491-7220
www.northviewmedicalhousecalls.com

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have received and have been presented with the opportunity to review the Northview Medical House Calls Plc (NVMHC) Privacy Notice during this visit/prior visit. I understand that I may obtain a copy of any future revised Notices on the Northview Medical House Calls Plc Web site. (www.northviewmedicalhousecalls.com)

AUTHORIZATION TO LEAVE MESSAGE & SHARING OF MEDICAL INFORMATION

In completing and signing this form, I authorize that NVMHC may leave a message on my home voice mail or cell phone voice mail containing medical information for a period of 12 months from the date signed on this form and as follows:

In the space below, if so desired, please indicate any personal *representatives/individuals who are permitted to receive or know information concerning your healthcare for the time you are under the medical care of NVMHC.. If your designated personal representatives changes during the time this form is in effect, you must contact NVMHC in writing and request the change.

With an individual(s) I designate as follows:

1. My Assisted Living facility or Adult Foster Care Home administrator/owner or nurse manager.
2.

*A personal representative as defined under the Health Insurance Portability Act of 1996 (HIPAA) is any family member, friend or individual designated by the patient to whom the patient's health information may be disclosed.

If you would like to change any of the information on this form, you must contact NVMHC in writing and request the change. This form must be signed and on file in your chart prior to any medical information being left on answering machines or with individuals you designate.

X _____

Date_____

Patient Name/Spouse/Nearest Relative/Legal Guardian