ANNUAL CONSENT FORM

PATIENT NAME: _____

PHONE NUMBER where we may leave detailed medical information: _____

MEDICAL TREATMENT CONSENT FORM

This Consent Form has been designed to acknowledge your acceptance of treatment recommended by your physician. This Consent Form is to be signed by all patients receiving medical treatment at GARDEN CITY MEDICAL CENTER, P.C. (the "Medical Practice")

My physician and/or his or her representative have explained to me the procedures planned for the treatment of my condition and the possible risk(s) associated with these procedure(s). I certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results of the proposed treatment, of the possible alternative forms of treatment; and the recognized serious possible risk,
complications, and the anticipated benefits involved in the proposed treatment and the alternative forms of treatment, including non-treatment.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of care, treatment, surgery, or examination in or by my physician or his or her associates or the employees or medical staff of the Medical Practice.

I have been informed that testing for HIV (human immunodeficiency virus – AIDS) – hepatitis, and /or other blood born agents posing occupational risk may be performed on me without my consent if a health professional or First Responder (police, firefighter, paramedic, etc.) sustains an exposure to my blood or other bodily fluid. I understand that this testing is required by Michigan law and, should testing occur, I will not be billed for it.

I further authorize the Medical Practice to dispose of at their convenience any specimens, or tissue taken from my body during my medical
treatment or surgery.

I understand that during the course of my treatment at the Medical Practice, my physician may need to consult with other physician(s) regarding my course of treatment. I understand that the Medical Practice maintains patient data both through electronic means, such as computers, and by keeping paper medical records. I authorize any physicians who consult with my physician to access any electronic or paper files that the Medical Practice has in its possession which pertain to my medical condition.

I consent to administration of such anesthetics as may be considered necessary or advisable by my physician.

I understand that any aspect of this Consent Form that I do not understand can be explained to me in further detail by my asking my physician or his or her associates. I certify that this Consent Form has been explained to me and that I have read it or have had it read to me, and that I
understand its contents. I also understand that a copy of these consents is available upon my request.

These consents shall expire one (1) year from the date that I have signed this Consent Form, unless revoked earlier by me.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that:

- I received a copy of the Medical Practice's Notice of Privacy Practices.
- I was able to review the medical Practice's Notice of Privacy Practices at the place where I went for health care services.
- The Notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices.
- I know that I can ask for a copy of the Notice of Privacy Practices to take with me.
- I was able to view the Notice of Privacy Practices on the first day I received health care services after April 14, 2003.
- If I came in for health care services in an emergency treatment situation, I was able to view the Notice as soon as reasonably practical after the emergency treatment situation ended.

FINANCIAL CONSENT FORM

Consent to Release Medical Records and Information to My Insurance Company: I authorize GARDEN CITY MEDICAL CENTER, P.C. (the "Medical Practice") to release information from my medical records to any person, organization, employer (if work-related injury), or review agency which is legally or contractually responsible for payment of my bills for services. I further authorize the Medical Practice to release information from my m medical records to auditors and consultants who are advising the Medical Practice on third party payor billing issues and/or assisting the Medical Practice in preparing financial data and related documents. I understand that the Medical Practice will maintain the confidentiality of my medical records, but I further understand that the Medical Practice is not responsible for any breaches or of confidentiality of my medical records caused by other parties. This permission includes information that may be related to drug or alcohol abuse, psychiatric care, HIV testing, AIDS (Acquired Immunodeficiency Syndrome), HIV infection or ARC (AIDS related complex), and includes social worker/client communication and psychologist/client communications.

Consent to Disclose Information to Individuals Involved in Your Care or Payment of Your Care: I authorize the Medical Practice and its employees to release information from my financial or medical records to a person, organization, employer (if work-related injury), or review agency which is responsible, or which the Medical Practice reasonable thinks may be responsible, for the payment of my bills for my medical care.

Financial Agreement: I understand that the Medical Practice submits claims to insurance carriers as a courtesy to patients and that I am responsible for the balance owed unless the Medical Practice has agreed with the payor not to balance bill. I agree to pay for all services rendered to me without regard to any benefit limitations imposed by any third party payor, unless other arrangements are made in advance, to pay my account in full upon discharge from the Medical Practice; to pay any legal fees and interest at the legal rate which result due to my not paying my balance. I understand the Medical Practice accepts no liability for failure to meet any pre-cost certification required by my insurance carrier, and I agree that such certification has been or will be properly executed by me.

Assignment of Benefits: I hereby assign to the Medical Practice all of my insurance and managed care benefits due to me for services rendered to me by the Medical Practice. I authorize my insurance company and/or my managed care company to make payment directly to the Medical Practice.

I understand that any aspect of this Consent Form that I do not understand can be explained to me in further detail by my asking my physician or his or her associates. I certify that this Consent Form has been explained t me and that I have read it or have had it read to me, and that I understand its contents. I also understand that a copy of these consents is available upon my request.

These consents shall expire one (1) year from the date that I have signed this Consent Form, unless revoked earlier by me.

I acknowledge that I have read the above, am giving my consent to the above, and have been informed of my rights to privacy.

(X)

_____ _____

SIGNATURE of Patient/Representative/Legal Guardian **Date**