Consent to Treat

- I hereby voluntarily consent to and authorize the physician, his associates and assistants to provide medical and minor surgical treatment, including but not limited to diagnostic procedures, medication, administration, physical examinations and screening services, including drug screening as deemed necessary and advisable. 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 examination and treatment which I have hereby authorized.
- I authorize Lapeer Pediatrics, P.C. and its affiliates to release to any third party payer, or its representative. Insures, including Medicare, Medicaid, Blue Cross/Blue Shield, Commercial health, automobile no-fault, workers compensation, health maintenance organizations. Preferred provider organizations and managed care plans, which may be responsible for payment in my case or as required by law. Information from my medical records as is necessary in order to receive reimbursement for any billing rendered related to my treatment, including alcohol and drug abuse records protected under the regulations in 42 CFR, Part 2, if any and social services records, if any, and psychological service records including communication by me to a social worker or psychologist. I also authorize Lapeer Pediatrics P.C. to release to individuals or agencies which may provide services for my care such information from the record as in necessary to provide these services. I also authorize the release of information to any independent auditors or reviewers retained by any third party payer, private health insurers, or any employer providing health insurance benefits to me so that these auditors can analyze charges.
- I further understand that my treatment may require more than one date of service; therefore this consent shall carry full force and effect from the date of signature until I am discharged from treatment.
- I understand that; the public Act No. 488 to 1988 State of Michigan states that an HIV treatment may be performed upon me without any additional consent., if a health professional or employee has a percutaneous, mucous, or open wound would exposure to my blood or other body fluids.
- I acknowledge that I have access to Lapeer Pediatrics, P.C. Notice of Privacy Practices on site in paper form and online at www.HarastaniMD.com.

(If Applicable) Phone Consent obtained from:_____ witness staff:_____

_____ _____ _____

Signature (Patient/Legal Guardian) Relationship Date

_____

Print Name (Patient/Legal Guardian)