

Michigan Advanced Pain & Spine

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General Consent Form

PATIENT'S NAME: _____ PATIENT'S SSN: _____

- 1. CONSENT:** I consent to routine medical, nursing care including routine procedures, examinations, tests, immunizations, regional and local anesthesia and other treatment by (Dr/ P.A.-C/ NP) _____ and his/ her assistants, associates or consultants as are necessary in their judgment. I know if I have any questions about my care of tests, I should be sure to ask the doctors/ nurses/ staff about them. I know it is up to me to tell the doctors/ nurses/ staff about any health problems or allergies I have. I must also tell the doctors/ nurses/ staff about drugs or medications I am taking. I consent to the testing and disposal of specimens of my blood, urine, and other bodily fluids, tissues and products. I understand that an HIV (human-immunodeficiency virus) and/ or a HBV (hepatitis B virus) or HCV (hepatitis C virus) test may be done upon me without any further consent if a doctor, health professional or employee sustains a percutaneous, mucous membrane or open wound exposure to my blood or other bodily fluid.
- 2. ADDITIONAL CONSENT FORMS:** I understand that for certain procedures deemed necessary by my physician(s), I will be required to sign a special consent form. Further, if I do not fully understand a procedure or its risk, consequences and alternative methods of treatment, I have the right to question the appropriate health care professionals.
- 3. RELEASE OF INFORMATION:** Michigan Advanced Pain & Spine releases patient health care information for purposes of treatment or payment, or to other healthcare organizations, as explained in our HIPAA Notice of Privacy Practices.
- 4. INSURANCE:** I authorize the doctor and staff to review my insurance coverage with my insurance company. I authorize payment of my insurance benefits to be made directly to the (Dr/ P>A>-C/NP). I agree to pay in full any and all charges not covered by insurance or other benefits. I understand providers may bill separately.
- 5. NO GUARANTEES:** I understand that the practice of medicine is not an exact science and that no guarantees or promises have been made to me as a result of treatments or examinations by the doctors or assistants. I understand that no contract, warranty, guarantee, or promises concerning the results or medical service is made. This consent to treatment form is not a contract, nor is it an offer to contract, nor is it an acceptance of an offer to contract.
- 6. PERSONAL PROPERTY:** I understand and agree that Michigan Advanced Pain & Spine shall not be liable for the loss or damage of any personal property which may or may not be given to Michigan Advanced Pain & Spine staff during my stay at one of the offices.
- 7. NOTICE OF PRIVACY PRACTICE:** I have received a copy of the Notice of Privacy Practices. I understand that additional copies will be provided to me upon request.

I CERTIFY THAT ANY AND ALL INFORMATION PROVIDED BY ME IN FUTURE OF MY APPLICATION FOR HEALTH CARE BENEFITS ARE TRUE. I HAVE READ THE FRONT AND THE INFORMATION IN THE BACK OF THIS FORM. IT HAS BEEN FULLY EXPLAINED TO ME, AND ALL OF MY QUESTION ABOUT THE FORM HAVE BEEN ANSWERED. I UNDERSTAND ITS' CONTENTS.

(PATIENT'S SIGNATURE) (DATE) (PERSONAL REPRESENTATIVE'S SIGNATURE) (DATE)

(WITNESS) (DATE) REPRESENTATIVE'S AUTHORITY TO ACT/ RELATIONSHIP TO PATIENT)