BLOOMFIELD VEIN & VASCULAR

43700 Woodward Avenue, Suite 207

Bloomfield Hills, MI 48302

(248) 481-2100

1. CONSENT TO MEDICAL CARE AND TREATMENT

I am being treated at Bloomfield Vein & Vascular and I consent to all medical and surgical care, examinations and test determined by my Physician that is necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my Physicians recommendations as they may relate to my health that the Physician and Bloomfield Vein & Vascular will not be responsible for any injuries and or damages that are the result of my non-compliance. I understand that is an employee or individual associated with Bloomfield Vein & Vascular is exposed to my blood or body fluids; I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing.

2. CONSENT TO USE OF IMFORMATION

Electronic Health Records. I understand that the Bloomfield Vein & Vascular may collaborate with other health care providers to coordinate, manage and provide health care to me and I consent to Bloomfield Vein & Vascular's sharing my health information records electronically for the purpose of treatment, payment or operations, including the overall quality of health care services provides to me. (e.g., avoiding unnecessary or duplicate testing, etc.) I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental and substance abuse, etc. Bloomfield Vein & Vascular has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my medical information as required by HIPAA.

Use and Disclosure of Information. In addition to the above consent to use and share my information with other facilities, I agree that Bloomfield Vein & Vascular may use and disclose my health information for a range of purposes including: treatment, eligibility verification, and/or payment to private or public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Workers' Compensation programs, obtaining pre-admissions or continued length of stay certifications, quality of care assessments and improvement activities, evaluating the performance of qualifications of physicians and health care workers, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory accreditation requirements and public health and health oversight services.

Request for Information from Others. I consent to Bloomfield Vein & Vascular to request my health information from other providers for the care of me, receipt of and release of my health information, weather written, verbal, or electronic, for the uses described above as well as the Physicians Office's participation in any health information exchange described in Bloomfield Vein & Vascular's Notice of Privacy Practices (NPP). Please refer to the NPP for additional, detailed information regarding the uses and disclosures of protected health information.

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACYPRACTICES

I acknowledge that I have received or have been offered a copy of Bloomfield Vein & Vascular's Notice of Privacy Practices which provides information on how Bloomfield Vein & Vascular may use or disclose PHI for purposes of treatment, payment, or healthcare operations.

Please Initial_____

ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment and all insurances and health care benefits available to me directly to Bloomfield Vein & Vascular for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.

FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health benefits, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid or other insurance payers (e.g., services rendered by healthcare providers who do not participate with my insurance plan). Non-covered services also may include those services my physician determines to be medically necessary, but are later determined unnecessary by the payer.

PERSONAL VALUABLES. I understand that Bloomfield Vein & Vascular does not accept any responsibility for any lost, stolen, or damaged personal items while I am on the premises.

Patient Name_____ Date _____

Print Name_____