



Consent General Treatment and Release of Information

NOTICE OF NONDISCRIMINATION:

West Michigan Foot and Ankle PLLC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. West Michigan Foot and Ankle PLLC does not exclude people or treat them differently because of race, color, national origin, age, disability, sex or any other basis prohibited by law.

I AGREE:

- To examination and treatment by providers, residents, students, and other healthcare professionals at West Michigan Foot and Ankle PLLC. This may include in-person, telemedicine, videotaping, photographing and audio devices. These tools may be used to treat/diagnose or for procedures to be performed for medical, scientific and/or personal safety.
- That the provider may change my and/or my child's care to benefit my life or health.

I UNDERSTAND THAT:

- I will ask questions.
- No one has made promises or guarantees about the results of my treatment or care. I am aware the practice of medicine and surgery is not an exact science. No guarantees have been made to me as a result of my treatment or examination at West Michigan Foot and Ankle PLLC.
- Students and staff may see me and look at my medical record for teaching or research purposes.
- The staff will double-check who I am. They will ask what I am having done. This is to protect me.
- Michigan law allows healthcare providers to test my blood for HIV (AIDS virus) or Hepatitis without my consent if someone who has helped in my care is exposed to my blood or body fluids.
- West Michigan Foot and Ankle PLLC will not tolerate discrimination against my provider, other healthcare professionals or staff because of race, color, gender, national origin, age, disability, sex or any other basis prohibited by federal, state or local law.
- Should my condition require referral to a specialist, I understand I will be asked my choice of a provider. I will have the opportunity to have West Michigan Foot and Ankle PLLC contact the provider of my choice or if I do not have a preference, an independent provider from West Michigan Foot and Ankle's "on-call" list will be called. I consent to my insurance company billing for professional services given by this provider whether or not this provider participates with my insurance program.
- This consent is valid for one (1) year from the date of my signature.

MY MEDICAL INFORMATION:

WEST MICHIGAN FOOT AND ANKLE MAY RELEASE MY MEDICAL INFORMATION TO:

- Insurance companies, health plans and administrators for payment of services I or my child receive(s).
- Government agencies like Medicare and Medicaid or as required by law.
- My providers and others involved in my care now or in the future.
- My employer, if the records are related to care or services paid for by my employer, or for other purposes that are allowed under law.
- Any person or entity responsible to pay all or part of my bill.

MY MEDICAL INFORMATION: (*continued*)

- I understand West Michigan Foot and Ankle PLLC will keep my or my child's medical information according to state law, federal law and policy. I also understand that my medical information may be stored electronically and may be sent to or received from other healthcare providers and/or payers electronically.



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- This includes my diagnosis, treatments, and medicine or prescription information. This may also include details about my mental health, infectious diseases, and other problems like drug or alcohol use disorder.
- In some cases, West Michigan Foot and Ankle PLLC is required by law to report medical information to an agency like the health department. This may include information about HIV, TB and other diseases.

PRIVACY NOTICE:

- I have rights and responsibilities when I or my child receive(s) services. West Michigan Foot and Ankle PLLC has made its Notice of Privacy Practices available, and I have had an opportunity to ask questions about the information in the Notice.

AUTHORIZATION TO RECEIVE PAYMENT AND BILLING:

- West Michigan Foot and Ankle PLLC is authorized to seek payment from any third party and from me. I authorize West Michigan Foot and Ankle PLLC to act on my behalf to collect benefits from any third party and endorse checks payable to me and/or West Michigan Foot and Ankle PLLC.
- I authorize any insurance company, responsible for payment of my medical care and treatment, to pay West Michigan Foot and Ankle PLLC for the services given. I understand that I am responsible for any charges not covered by insurance.
- I request payment due to me of authorized Medicare benefits be paid (on my behalf) to West Michigan Foot and Ankle PLLC for any services provided to me by West Michigan Foot and Ankle PLLC or in its facilities.
- I agree that if my account is not paid when due, the practice may retain a lawyer and/or collection agency for collection. I will be responsible to reimburse the practice for all costs, charges and fees associated with the collection of the amount due. This includes, but not limited to, reasonable interest, legal cost in the event a suit is filed and reasonable lawyer fees and/or reasonable collection agency fees including those based on a percentage of the debt.
- If you do not want us to bill your insurance, you must notify us at the time of service.

PATIENT SIGNATURE(S):

I have read this form and I understand it. All my questions have been answered.

TIME: _____ AM/ PM DATE: _____ PATIENT SIGNATURE: _____

IF YOU ARE A PARENT/LEGAL GUARDIAN/PATIENT ADVOCATE/ NEXT OF KIN SIGNING FOR THE PATIENT:

PATIENT IS UNDER 18 YEARS OF AGE

PATIENT IS UNABLE TO CONSENT BECAUSE: _____

TIME: _____ AM/ PM DATE: _____ SIGNATURE: _____

PRINTED NAME OF PARENT/LEGAL GUARDIAN/PATIENT ADVOCATE/ NEXT OF KIN: _____

RELATIONSHIP TO PATIENT: _____