

CONSENT FOR TREATMENT

I hereby consent for treatment at this facility for either myself or my minor child or another person for whom I have medical power of attorney) listed below. This consent will remain valid unless cancelled in writing. I understand that all treatments, including medical treatment, x-rays, blood tests, laboratory tests, and other diagnostic tests deemed appropriate by my physician, or even lack of treatment carries certain risks and benefits. I understand that the physicians at Michigan Hand Center, PLC, will help me to understand the benefits and common risks of any recommended treatment. It is my responsibility to request further information if there is anything about the risks and benefits that I do not understand.

I understand that minor procedures such as injections, placement of stitches, or removal of stitches may sometimes lead to side effects such as pain, bruising, bleeding, scarring or infection in spite of best efforts to prevent those effects. Although these risks of any minor procedures in the office may be reviewed prior to such procedure, this constitutes my acknowledgement of the inherent risks of any such procedure, and no further written consent will be obtained.

For the purpose of advancing medical knowledge, I consent to the presence of other physicians, medical personnel, orientees, and students. I consent to taking and publishing pictures and television of the surgery/invasive procedure provided my identify is not revealed.

NOTIFICATION REGARDING PATIENT BODY FLUID EXPOSURES

Michigan Law allows a health care facility to have a policy of testing patients for Hepatitis Virus and/or Human Immunodeficiency Virus (HIV) if an exposure to blood or other body fluids occurs.

If an employee, physician or affiliate of Michigan Hand Center becomes contaminated with a patient's blood or body fluids through any type of exposure, the patient's blood may be tested for the Hepatitis Virus and/or the Human Immunodeficiency Virus (HIV), which causes Acquired Immune Deficiency Syndrome (AIDS). There will be no charge to the patient for this testing, and the results of the testing will be treated confidentially.

NOTIFICATION OF INFORMATION RELEASE AND PAYMENT RESPONSIBILITY

I hereby authorize the physicians and staff at Michigan Hand Center, PLC, to release medical information including my diagnosis, medical history, and other material contained within those records to referring physicians, hospitals, laboratories, pain clinics, therapists, and employer(s) as deemed necessary. I also authorize the release of information necessary for processing my insurance, liability, Workers' Compensation or litigation claims. I authorize payment of benefits, where applicable, directly to those physicians otherwise payable to me for their services. If these benefits are not assigned to Michigan Hand Center, PLC, I agree to forward to the practice all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. Should my account be assigned to a collection agency due to my failure to pay, I agree to pay all agency costs associated with collection of my account. I understand that a statement fee may be added to my account if I do not pay my copayment on the date of service. I have had the opportunity to review the financial policy of Michigan Hand Center, PLC. I agree to the terms of this policy, and I accept the responsibility for my bills and understand payment is expected when the service is given.

Signature of Patient or Representative

Date