

CONSENT FOR TREATMENT & RELEASE OF INFORMATION

1. I hereby voluntarily request, consent to and authorize Dr. Caroline D Mathew, her associates, and assistants to provide medical and minor surgical treatment, including but not limited to diagnostic procedures, x-rays, medication administration, physical examination and screening services, including drug/alcohol screening, as is 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.

2. I authorize Dr. Caroline D Mathew to release to any third party payer, or its representative, including Medicare, Medicaid, Blue Cross/Blue Shield, Commercial health insurers, automobile no fault insurers, worker's disability compensation insurers, employers, health maintenance organizations, preferred provider organizations and managed care plans, which may be responsible for payment in my case, or as required by law, such information from my medical record as is necessary in order to receive reimbursement for any billings rendered relating to my treatment, including alcohol and drug abuse records protected under the regulations in 42 CFR, Part 2, if any, and social service records, if any, and psychological service records including communications by me to a social worker or psychologist, authorize Dr. Caroline D Mathew to release to individuals or agencies which may provide services for my case such 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 that this independent auditors can analyze charges.

3. 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.

4. I hereby assign payment directly to Dr. Caroline D Mathew the insurance benefits otherwise payable to me but not to exceed the balance due to Dr. Caroline D Mathew and her affiliates for charges for these services.

5. I authorize Dr. Caroline D. Mathew to retrieve medication history through the Surescripts e-prescribe.

6. I assume full financial responsibility for payment of all services provided to me, including any portion of my bill that is not paid by insurance, workers' disability compensation or social agencies.

7. Dr. Caroline D Mathew may perform an HIV test upon me without written consent, as stated in Public Act # 488 of 1988 of the State of Michigan, if a health professional or employee has percutaneous, mucous membrane, or open wound exposure to my blood or body fluids.

8. I understand the content and significance of this form, and my questions have been answered.

Signature of Patient or Patient representative

Date

Witness

Please list below anyone that you would like to have access to your medical information or that we may give results too.

Name

Relationship

Phone

Name

Relationship

Phone