NOTICE OF PRIVACY PRACTICES

* A copy of the Notice of Privacy Practices is posted and available to me upon request.
* I have received a copy of the Office Policies of Dr. Caroline D. Mathew
* I have received an outline of the Patient Centered Medical Home agreement.

Patient Signature _____ Date _____

MEDICAL CONSENT

I voluntarily and knowingly request and consent to the outpatient services which may include medical treatment, blood/laboratory services and other diagnostic testing deemed appropriate by Dr. Caroline D. Mathew, or other medical providers. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the results of care, treatment or examination.

I understand and consent to testing of HIV, hepatitis and/or blood borne agents posing occupational risk may be performed on me if a health care professional sustains an exposure to my blood or other bodily fluids. I understand that this testing is permitted by Michigan law and should such testing occurred I will not be billed for it.

I consent to any extraction and/or disposal of any specimens or tissue taken from my body during treatment. I understand that these consents include the use of information that may be related to drug or alcohol abuse, psychiatric care, HIV testing, AIDS, HIV infection ARC (AIDS related complex) and may include social worker/client communication and psychologist/client communications.

Patient Signature _____ Date _____

DESIGNATION OF AUTHORIZED REPRESENTATIVE

Under the Health Insurance Portability Act (HIPA), you have the right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing Dr. Caroline D. Mathew and staff of your wish to designate the named person(s) as your authorized representative(s). You may revoke the designation at any time by notifying this office in writing.

REPRESENTATIVE _____ RELATIONSHIP _____

REPRESENTATIVE _____ RELATIONSHIP _____

My designated representative(s) is afforded all of the privileges that would be afforded to me with respect to my protected health information.

Patient Signature _____ Date _____