GENERAL CONSENT FORM

Patient Name:_____ Date:_____

Social Security Number:_____

1. I hereby do voluntarily consent to such care including routine procedures, examinations, tests, immunizations, vaccinations, regional or local anesthesia and other treatment by University Physician Group professionals and their assistants, appointees, or consultants as is necessary in their judgment.

2. If I don't fully understand a procedure or its risks, consequences and alternate methods of treatment, I have the right to question the appropriate health care professionals.

3. I realize that University Physician Group and their practice sites are teaching facilities affiliated with Wayne State University and that some procedures may be performed by students, residents and/or fellows under the supervision of the attending staff.

4. I understand that blood may be drawn from me for HIV testing without further permission being given by me if a doctor, other health professional or employee is exposed to my blood or bodily fluids.

5. I understand that University Physician Group shall not be responsible or liable for the loss of or damage to any personal property.

6. I authorize the release to any party responsible for my care, such information from my records as is required in order for the University Physician Group and all entities providing services to obtain payment. This includes records of alcohol and drug abuse and/or treatment, records indicating testing, diagnosis or treatment for HIV infection, or any related condition, records of psychological services and social services, including communications made by the patient to the physician, social worker or psychologist. This authorization shall be effective only so long as necessary to obtain payment or reimbursement and will end when payment or reimbursement is received.

7. I authorize University Physician Group to review my insurance coverage with my insurance company.

8. I authorize payment of insurance benefits to be made directly to University Physician Group.

9. I permit a copy of this authorization to be used in place of the original.

I have read this form and my questions have been adequately answered and I certify that I understand its contents.

Signature of Patient:_____

Signature of Witness:_____

Signature of Parent or Guardian:_____