Great Lakes
Medical Associates

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CONSENT FOR TREATMENT

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

CONSENT RELATED TO PRIVACY NOTICE:

I have had a chance to review the Privacy Notice as a part of this registration process. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

CONSENT FOR CARE:

I, with my signature, authorize Great Lakes Medical Associates PC, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

CONSENT FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in our Privacy Notice. I also certify that the information I provided to this practice is true and correct. Any discrepancies in my information may result in responsibility of payment.

NO SHOW POLICY/LATE CANCELLATION:

A "no show" is a patient that misses an appointment without canceling it within one (1) business day in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in your medical chart as a "no show". An administrative fee of $50.00 for office visits and $75.00 for procedures will be billed to your account. You will be sent a letter alerting you to the fact that you failed to show for a scheduled appointment and did not cancel the appointment within one (1) business day in advance along with the bill for the administrative fee. A copy of the letter will be placed in your medical record. Three (3) "no-shows" within a 365-day period will result in discharge from the practice. A Patient will be considered a "no-show", if they arrive ten minutes or later for their appointment time. This will also be subjected to the "no-show fee and may be rescheduled.

Please note that No-Show charges are patient responsibility and will **not be billed to your insurance company.

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care.

I have read and understand the Consents stated above and agree to accept full responsibility as described above.

_____ _____

Patient/Responsible Party Date

_____ _____

GLMA Staff Witness Date

Patient Name if Different from Responsible Party: _____