LINCOLN MEDICAL
3353 FLECKENSTEIN DR.
FLINT, MI 48507

1. CONSENT TO TREATMENT.

I, _____, voluntarily request, consent to and authorize Doctors S. Kiran/Mona Hardas and/or staff under his/her orders attend to me at Lincoln Medical, and to provide medical and surgical treatment and care, including, but not limited to diagnostic procedures, administration of medications, as is deemed necessary and advisable.

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 to the result of treatments and examination in the office.

Signature of Patient of Legal Representative: _____

DATE: _____

2. PATIENT'S PERSONAL POSSESSIONS. The office is not responsible for any patient's clothing, valuables or other personal belongings. I hereby release the office from any liability for any and all personal possessions that I choose to keep with me or bring to the office.
3. RELEASE OF INFORMATION. I hereby authorize the office, its Director or designee, to release information, in written form, by phone, or facsimile machine, contained in the patient's medical records. I specifically authorize the release of drug and alcohol abuse records in accordance with Federal Regulations and/or communications made by me to a social worker or psychologist and/or records pertaining to communicable diseases. I further specifically authorize the release of information regarding: Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), Acquired Immunodeficiency related Complex (ARC) to:

   (a) Any third party payor, employer, or insurance company (including but not limited to Medicare, Medicaid, maternal and infant health, Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, workers disability compensation insurers, and health maintenance organizations) which are responsible in whole or part for paying the patient's office bill so that the office may receive payment or reimbursement for the services provided to the patient.
   (b) Any health care facility, physician, durable medical equipment supplier, or other ancillary services provider to which the patient is referred or transferred or to which referral/transfer is contemplated for the purpose of facilitating continuity of the patient's health care, and
   (c) Any independent auditors hired or retained by any and all third party payors, private health insurers and/or any employer providing health insurance benefits to the patient, applicable to the patient's office visit, for the purpose of enabling these independent auditors to analyze charges made for services rendered to the patient.
   (d) The release authorization shall be effective only so long as it necessary to accomplish the purpose for which it is given. With respect to substance abuse (if any), this consent may be revoked at any time unless the office has already released information in reliance upon it.
   (e) "I understand that the falsification of statements or fraud (including the unauthorized use of someone else's name or information), authorizes Lincoln Medical to disclose, as necessary, any and all information used in the fraudulent act. "

4. ASSIGNMENTS OF INSURANCE BENEFITS. I hereby assign, transfer and set over unto Lincoln Medical as its interest may appear all benefits now due or becoming due to me by virtue of the present office treatment.
5. AGREEMENT TO PAY FOR SERVICES. I understand that I am liable and responsible for any health insurance deductibles and coinsurance portions of my office bill. I also understand that I am responsible to pay for all services to be rendered to the patient whether signing as agent or as patient.
6. OTHER CHARGES FOR SERVICES. I understand and agree that there may be a $25.00 charge, payable to the office, if they are required to do a prior authorization for a medication or radiology service that I, or the physician, deems

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necessary. If the physician is required to do a peer to peer review with my insurance company I agree to pay the physician a fee of $200.00.

7. NO SHOW FEE. I understand that I will be charged a $25.00 fee if I fail to call the office to let them know that I will not be coming to my appointment.
8. ADVANCE DIRECTIVES. I understand that I have the right to provide the office with advance directives regarding medical treatment decisions, including the right to refuse unwanted medical treatment or ask that it be withdrawn. I currently do____ do not____ have any such directives formally written.
9. PARTICIPATION IN RESEARCH. All research studies are subject to a special approval process, which will have occurred prior to your being approached for participation. Your participation in any such study is voluntary, and you may refuse or discontinue participation at any time and there will be no effect or influence on the care you receive. I hereby authorize an employee of the office, or agent thereof, to approach me for participation in a research study.

I further understand and acknowledge that an HIV test may be performed upon myself, without the written consent required under circumstances that a health professional, other health facility employee or emergency first responder (as defined in Act 419 of 1994), sustains a percutaneous mucous membrane , or open wound exposure to my blood or other body fluids.

The undersigned certifies that (s)he has read the foregoing or that it has been read to him/her, and that (s)he understands the same and consents thereto, and that (s)he is the patient or the duly authorized representative or agent of the patient to sign this form and consent thereto. I further understand that my consent shall carry full force and effect from the date of signature until I am discharged from further treatment.

DATE: _____ **TIME**: _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____

RELATIONSHIP, IF OTHER THAN PATIENT: _____

SIGNATURE OF WITNESS: _____

If patient is unable to sign, or is a minor, complete the following:

Patient is (a minor, _____ years of age, or is) unable to sign because:

_____

_____