John N Campbell MD PC
Internal Medicine / Addiction Medicine

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GENERAL CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

PATIENT NAME_____DATE_____

TREATMENT

I agree to all treatment and procedures the doctor and other healthcare professionals have ordered.

I agree to ask questions so that I fully understand all treatment.

Students and staff may see me and look at my medical record for teaching or research. They will not publish information identifying me unless I agree.

The staff will double-check who I am by obtaining a copy of my photo ID. This is to protect me.

You may test my blood for HIV (AIDS virus) or Hepatitis if someone who has helped me in my care is exposed to my blood or body fluids. This can be done without my consent because Michigan Law allows this to protect healthcare professionals.

MY MEDICAL INFORMATION

John N Campbell, MD, may release my medical information to:

1. My doctors and others involved in my care now or in the future.
2. Insurance companies that may be responsible for paying for my services.
3. Government agencies like Medicare and Medicaid or as required by law.
4. My employer if the records are for evaluation or for other services requested by my employer.
5. Anyone responsible for all or part of my bill. I agree this can include information about drug or alcohol abuse, mental illness, HIV or related illnesses. I can cancel in writing this permission to release medical information unless the information was already sent.

I agree that my medical information may be stored electronically and may be sent to or received from other healthcare providers and/or payers electronically. This may include prescription or medication information.

In some cases John N. Campbell, MD, is required by law to report medical information to an agency like the health department. This may include information about HIV, TB and other diseases.

CHARGES FOR TREATMENT

I know that I am responsible for all charges not covered by my insurance company.

I give permission for my insurance to pay John N. Campbell, MD, directly for the treatment or procedures covered by my insurance.

I understand I am responsible to pay any copayment, coinsurance or deductible and to pay for any services not covered by my health plan.

I agree to help pursue any appeals if my health plan does not pay any or parts of my bill known to be a covered benefit.

PRIVACY NOTICE

I understand that I have rights and responsibilities when I receive services. I acknowledge that this information has been given to me.

PATIENT SIGNATURE

By signing this form I acknowledge that I understand it and that all of my questions have been answered.

PATIENT SIGNATURE_____**DATE**_____

Patient is under 18 years of age or otherwise unable to consent because_____
_____
_____.

SIGNATURE_____

RELATIONSHIP TO PATIENT_____

STAFF SIGNATURE_____**DATE**_____

STAFF SIGNATURE_____**DATE**_____
(2nd witness only for verbal consent)