HAND SURGERY of Northern Michigan

SURGERY OF THE WRIST AND HAND

Mark S. Leslie, M.D. | Paul A. Jacobson, M.D. | Danielle A. Conaway, M.D.

AUTHORIZATION FOR TREATMENT

I know that I have a condition requiring medical treatment. I voluntarily consent to all procedures and treatment deemed necessary by the treating provider, medical staff and other healthcare professionals of HSNM. I am aware that the practice of medicine and surgery is not an exact science and the diagnosis and treatment may involve risks. I acknowledge that no guarantees, assurances or warranties (oral or written) have been made by anyone as the result of my care and treatment.

I further understand that, as part of HSNM's electronic medical record system, my patient demographics will be data-shared with the Munson Healthcare system and my medical records may be shared with any medical provider I am referred to as a result of my encounters with HSNM.

I understand that payment in full or insurance co-pay/deductible is expected at the time of services rendered. I also request payment of insurance benefits be made to myself or on my behalf to HSNM.

By signing below, I acknowledge that I have been offered a copy of HSNM's Notice of Privacy Practices and have received a copy of HSNM's New Patient letter for review.

I authorize HSNM to retrieve or release any medical records, x-rays, or test results that are needed to assist with my treatment and/or processing of my insurance claims.

I authorize HSNM to E-Prescribe my prescriptions and use my prescription history from other healthcare providers or third party pharmacy benefit payors for treatment purposes and enrollment in the E-Prescribe program.

****Additional form available to release medical and claim information to family members****

I agree to receive phone calls, pre-recorded/artificial voice message calls and/or use of automatic dialing device, SMS messages, text messages and/or emails from HSNM, our partners, subcontractors, or any and all other companies that we may have to transfer your account to at any telephone number or email address that you have provided us or that we have otherwise obtained, which could result in charges to you. We may place such calls, texts or emails to notify you regarding upcoming appointments, notify of results, troubleshoot problems with your account, resolve a dispute, collect a debt, or as otherwise necessary to service your account or enforce this treatment agreement, our policies, applicable, law, or any other agreement we may have with you. Standard telephone minute and text charges may apply if we contact you. You may revoke this consent at any time by calling us at (231)935-0800.

Date: _____ Patient Signature_____

Responsible Party, if Minor: _____

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