Digestive Health Center of Michigan
Patient Demographic/Consent to Treat

Last Name:	First Name:	Middle Ini:	DOB:
Address:			
City:	State:	Zip:	Home Phone:
Cell Phone:		SSN:	
Marital Status:	Sex:	Referring Doctor:	
Race: ☐ African Amer ☐ Asian ☐ White ☐ Pacific Islander ☐ Other		Ethnicity: ☐ Hispanic ☐ NonHispanic	
Emergency Contact:		Contact Number:	

Primary Insurance:	
Contract Number:	Group:
Subscriber's Name:	Subscriber's DOB:

Secondary Insurance:	
Contract Number:	Group:
Subscriber's Name:	Subscriber's DOB:

Pharmacy Name:	Pharmacy Phone:
City/ Cross Streets:	

Consent to treat- I authorize and consent to the treatment deemed necessary by the physician for myself or my child, which may include assessment of health status/history, first aid, necessary minor procedures, physical examination, health education, referral and follow-up.

Assignment of Benefits- I authorize payment of benefits to Digestive Health Center of Michigan for the services rendered. I understand that to the extent permitted by law, I am responsible for any costs not covered under my insurance plan.

Release of Information for Payment- I authorize the release of any medical or financial information, including any information related to AIDS, AIDS Related Complex (ARC) or HIV and any information regarding substance abuse treatment protected by 42 Code of Federal Regulation (CFR), part 2, and any mental health treatment, to any third party responsible for paying all or part of my (or my child's) medical bill. I understand that this authorization to release information may be revoked at any time and is only for the purpose of obtaining payment.

No Guarantee of Results of Care and Center's Termination Rights- I agree no one has promised or guaranteed any results of my or my child's medical care. I agree that nothing in this form prevents the medical center and it's staff from terminating my or my child's care if I am give reasonable notice and a chance to obtain medical services elsewhere.

Consent to HIV Testing- I understand that if a person working at the hospital is exposed to blood or body fluids while providing me care, the hospital may test my HIV Status in accordance with Michigan Public Health Code 1988, Public Act 488.

Patient/Parent/Guardian Signature Date

Witness Signature Date