IMWM
Internal Medicine of West Michigan, PLLC
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Suite 102
Grand Rapids, Mi 49525
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imwm.healthcare

GENERAL CONSENT FOR TREATMENT

I voluntarily authorize and consent to the medical examination and treatment by providers, residents, students, and other healthcare professionals at Internal Medicine of West Michigan, PLLC. This may include in-person, shared medical appointment, telemedicine, videotaping, photographing and audio devices. These tools may be used to treat/diagnose or for procedures to be performed for medical and/or personal safety.

Michigan law allows healthcare providers to test my blood for HIV (AIDS virus) or Hepatitis without my consent if someone who has helped in my care is exposed to my blood or body fluids.

In some cases, IMWM 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.

GENERAL, TREATMENT AND RELEASE OF INFORMATION

I assign Internal Medicine of West Michigan, PLLC: All benefits, claims, and any and all other rights, including the right to bill and talk to any third party for the purpose of seeking payment, regarding my charges at IMWM. The right to take any other action to seek payment of my charges at IMWM. This assignment includes, but is not limited to, the right to appeal the denial of payment of my IMWM charges from any payer, including any employer-sponsored benefit plan, insurance policy or insurance coverage provided by law or contract.

NOTICE OF NONDISCRIMINATION: IMWM complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. IMWM does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex or any other basis prohibited by law.

ACKNOWLEDGEMENT OF FINANCIAL/OFFICE POLICY

I acknowledge receiving Internal Medicine of West Michigan Financial/ Office Policy. This policy explains my financial responsibility and office policies. This policy can be found on or website or I can request a paper copy.

CONSENT TO FOR MEDICARE AUTHORIZATION (MEDICARE ONLY)

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in Internal Medicine of West Michigan, PLLC including physician services. I authorize any holder of medical or other information about me be released to the Centers for Medicare and Medicaid and its agents any information needed to determine these benefits or benefits for related services.

ACKNOWLEDGMENT OF RECEIPT OF PATIENT CENTERED HOME

I acknowledge I have received (or have been offered) a copy of Internal Medicine of West Michigan **Patient Centered Medical Home Informational Document.** This document can also be found on our website.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge I have received (or have been offered) a copy of Internal Medicine of West Michigan Notice of Privacy Practices that explains when, where, and why my protected health information may be used or shared by Internal Medicine of West Michigan, PLLC. I understand that I may request additional restrictions on the use and disclosure of my PHI or for additional confidential treatment of communications.

CONSENT TO CONTACT

I have given residential and/or cellular telephone numbers and an email address to Internal Medicine of West Michigan. I consent to receive autodialed and/or pre-recorded telephone calls, text messages and/or emails from IMWM and/or its agents/third parties. These communications may include billing.

AUTHORIZATION TO SHARE AND PERMITTED USE OF PROTECTED HEALTH INFORMATION (PHI)

I authorize Internal Medicine of West Michigan, PLLC to disclose or provide my protected health information to individual(s) I designated on the AUTHORIZATION TO SHARE AND PERMITTED USE OF PROTECTED HEALTH INFORMATION (PHI) FORM.

I understand my protected health information (PHI) may include very personal information (e.g., physical/mental illness, alcohol/drug abuse, sexually transmitted infections (STIs), HIV/AIDS, etc.). If I give someone access to my MyChart portal or request my PHI be shared with a third-party, that third-party will be able to see my PHI (which may include very personal information). By allowing others access to my PHI, I am agreeing that they can see my very personal information including my HIV/AIDS status.

Patient Name:_____ DOB:_____

Patient Signature:_____ Date:_____