Katranji Reconstructive Surgery Institute
2111 Merritt Road
East Lansing, MI 48823

Patient Medical Consent and Authorization Form

CONSENT FOR TREATMENT

I hereby give consent to Katranji Reconstructive Surgery Institute, PLLC ("KRSI") and its designated agents to provide evaluative and treatment services as necessary and reasonable for my care. I understand that during the course of my treatment an emergency situation may arise whereby the physician(s) may not be able to obtain my informed consent. I, thereby, authorize the physician(s) to use their best and reasonable judgment to perform any emergency procedures the physician(s) sees fit and reasonable. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I am aware of the risks associated with any treatment.

BILLING POLICY

In order to submit a claim for payment to us for services covered under your policy, I must have authorization to release medical information to your insurance company and to my billing company for paper & electronic billing. I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorized Katranji Reconstructive Surgery Institute, PLLC and their billing company to file for benefits on my behalf for services received. Insurance payments shall be made directly to Katranji Reconstructive Surgery Institute, PLLC or KRSI. If I have Medicare insurance, I authorize Katranji Reconstructive Surgery Institute, PLLC to release to the Social Security and Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I understand that I am financially responsible to pay any deductible, co-pay or other balance not paid by my health insurance. I understand that if I do not have any health insurance I am financially responsible for the entire balance for all medical and surgical care rendered. If the balance is not paid per our Patient Financial Responsibility Policy further collections efforts may apply. This authorization is valid indefinitely until revoked by myself or by Katranji Reconstructive Surgery Institute, PLLC by written request. I understand I have the right to request a copy of a Patient Financial Responsibility Policy.

NOTICE OF PRIVACY PRACTICES

The Federal government passed a law in 1996 called the Health Insurance Portability and Accountability Act (HIPAA). One of the provisions of the act is that as a consumer, the legal right to confidentiality of your health care information is essential in our efforts to deliver quality health care. In compliance with that law, we have some information that we need to give you regarding your rights and responsibilities related to the confidentiality of your medical record information. As your health care provider, Katranji Reconstructive Surgery Institute, PLLC, has an obligation to protect the confidentiality of your health care information. This notice of Privacy Practices is intended to give you some general information about this requirement.

This is an acknowledgement form that we need you to sign indicating that this information has been made available to you. Your signature only indicates that you have been made aware of the information. It does not indicate your agreement or disagreement with the provisions of the notice. Should you have any questions or concerns regarding this policy, you may contact our office at 517-332-4263.

I acknowledge that:

1. A copy of the Privacy Practices was made available to me at the location where I received health care services.
2. The *Privacy Practices* was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices.
3. I know that I can ask for a copy of the *Notice of Privacy Practices* to take with me, and I was offered a copy.
4. If I came in for health care services in an emergency treatment situation, I was able to view the *Notice of Privacy Practices* as soon as possible after the emergency treatment situation.

As a courtesy to you and the physicians that care for your health needs, a report of your visit(s) will automatically be sent to the physician that referred you to our office and/or your designated Primary Care Physician, unless you advise us otherwise.

_____ (Please initial indicated you have read and agree to the above information)

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With my consent, Katranji Reconstructive Surgery Institute, PLLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

The information below will assist us in your care and in any communications with you, while protecting your confidentiality. Please review, mark your selections, and fill in any necessary information. *You may amend this statement at any time.*

❒**YES** ❒**NO** Leave a message at my home and/or answering machine regarding scheduling.

❒**YES** ❒**NO** Leave message at my home requesting a return call.

❒**YES** ❒**NO** Leave message at my office requesting a return call.

❒**YES** ❒**NO** Leave message on my office voice mail regarding my health care.

❒**YES** ❒**NO** May speak with _____ regarding my treatment.

(please specify name and relationship).

❒**YES** ❒**NO** May speak or fax information to _____ (Employer) regarding my treatment.

_____

Printed name of patient or patient representative

_____ _____

Signature of patient or patient representative **Date**

_____

Relationship to patient (if other than patient)

Complete only if patient or representative signs by use of a mark:

_____

Printed name of witness

_____ _____

Signature of witness Date

_____

Printed name of witness

_____ _____

Signature of witness Date

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If the provided signature is that of a patient's representative/guardian, our office must complete the following:

Katranji Reconstructive Surgery Institute, PLLC has verified the identification of_____ (patient's representative name) by_____(type of verification, e.g. drivers license) and that in his/her capacity of_____ (description of authority to act, e.g. legal guardian, patient authorized representative, power of attorney for medical care including medical records, executor of estate).

Verification completed by:

_____ _____

Associate name and signature Date