COMPEAN
FAMILY MEDICINE

327 Stewart Road
Monroe, MI 48162

734-384-3660 phone
734-384-3661 fax

CONSENT FOR TREATMENT AND INSURANCE AUTHORIZATION

PATIENT'S
NAME ____ DATE__________________

DATE OF BIRTH ______/______/________ LAST 4 NUMBERS OF SOCIAL SECURITY NO: __________________

I ____, hereby voluntarily consent to outpatient medical care at Compean Family Medicine, PLLC, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), heart tracing and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including physicians' assistants, medical assistants, or their designees as is necessary in the medical staff's judgment.

I authorize my insurance company to pay all benefits directly to Compean Family Medicine, PLLC and thereby agree to the release of relevant medical information to insurance carriers.

I understand that this form will be valid and remain in effect as long as I receive medical care at Compean Family Medicine, PLLC.

My signature below indicates that I have read and agree with the information in this document. If you do not understand or consent to anything stated in this document, it is your responsibility to request and receive clarification before signing.

____

Date **Signature** **Witness**

If signed by patient's authorized representative, describe the representative's authority:

- ☐ Patient is a minor; I am the patient's parent and natural guardian.
- ☐ Patient is a minor; I am the patient's guardian, appointed by the ________________County Juvenile Court.
- ☐ Patient is a ward; I am the patient's guardian, appointed by the ________________County Probate Court.
- ☐ I am the patient's attorney in fact, as designated in the patient's Durable Power of Attorney for Health Care.
- ☐ Other (describe) ____

____

CONSENT TO TREAT MINOR PATIENT:

If patient is a minor, fill in below:

I, ____ the mother/father/guardian of ____

give Compean Family Medicine, PLLC permission to treat my child if presented to this office by the following individuals:

____ ____

____

Date **Signature** **Witness**