Advanced Reproductive Medicine and Surgery, P.C.
4190 Telegraph Rd., Suite 1500
Bloomfield Hills, MI 48302
(248) 203-0900
(248)203-0902 Fax

David Brinton M.D.
Alexander Maximovich M.D.

H.I.P.P.A.

Patient's Name ____ Date of Birth______________________

1. **Consent:** I request and authorize medical or surgical treatment as may be deemed necessary and appropriate by the physician and his/her designees and assistants participating in my care. This care may include diagnostic, radiology, and the laboratory procedures. Blood transfusions, anesthesia, therapeutic procedures, drugs, and medical, nursing, and laboratory care.

2. **Release of Information:** I authorize Advanced Reproductive Medicine and Surgery P.C. to release pertinent information and/or copies of medical records for treatment, payment or health care operations purposes. I understand such information may include: Human Immunodeficiency Virus (HIV), AIDS Related Complex (ARC), Acquired Immunodeficiency Syndrome (AIDS), Hepatitis, substance abuse, psychiatric/psychological service records, and social work records, if any. See notice of Privacy practices for further information.

3. **Human Immunodeficiency virus (HIV) and Hepatitis B (HBV) Testing**: I understand and agree that, in accordance with State law, and HIV and HBV test may be performed upon me in event a health care worker sustains a significant exposure to my blood or body fluids. The results of any tests will be treated confidentially.

4. **Testing and Disposal of Specimens and Tissues:** I authorize Advanced Reproductive Medicine and Surgery P.C. to retain, preserve, or use for research, scientific or teaching purposes or to dispose of any specimen or tissue remaining after completion of a clinical procedure or treatment.

5. **Valuables:** I release (ARMS P.C.) Advanced Reproductive Medicine and Surgery P.C. from responsibility for all personal articles which I have during the time I am a patient at the office. I understand that (ARMS P.C.) is not responsible for clothing, eyeglasses, dentures, jewelry, money or other personal articles of value kept in my possession or in the exam room, lab, or office at (ARMS P.C.). I understand personal valuables must be kept with me at all times for their safekeeping.

6. **Payment:** I assign and authorize payment from insurance company directly to Advanced Reproduction Medicine and Surgery P.C. (ARMS P.C.) for any and all services rendered. I agree to pay, at the time of service or an interim basis (agreed upon ARMS P.C.), charges not covered by my insurance company. I understand that it is my primary responsibility to pay (ARMS P.C.) all charges for services rendered irrespective and any disputes or disagreements between myself and insurance companies.

7. No Guarantees: I am aware that the practice of medicine and surgery is not an exact science and I acknowledge no guarantees or promises have been made to me as to results of the care and treatment which I have here authorized.

I have read this form or it has been read to me and I am satisfied that I understand its contents. I further understand that this consent will be deemed continuing and I am free to withdraw my consent at any time.

______________________ ____

Date Signature of Patient (if patient is minor) legal guardian/patient advocate/closest relative (if patient is unable to consent)

____ ____

Signature of Witness Please indicate relationship to above if not patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I received a copy of the Notice of Privacy Practices.

Acknowledgement of receipt of Notice of Privacy Practices was not obtained because
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Patient or Representative Signature Date (ARMS P.C.) Representative Date