



43151 Dalcoma Drive
Clinton Twp., MI 48038
Ph: (586) 286-8720
Fax: (586) 286-8723

CONSENT TO EXAMINATION AND TREATMENT: I understand and voluntarily consent to receive medical and health care services given by S.L. Husain Hamzavi, MD, his Associates and/or Assistants, collectively known as Hamzavi Dermatology and will be referred to as "HD" for the remainder of this document. I understand the examination procedures will be explained to me and I authorize the administration of all diagnostic and therapeutic procedures, examinations and treatments considered advisable or necessary in the judgment of the physician. I understand that the examination results will be provided to me with recommendations. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments. The responsibility for any follow up examinations to check abnormalities found and treated, lies with me and not with HD. I hereby release my examiner from all responsibility in connection with the examination.

CANCELLED OR MISSED APPOINTMENTS: We are happy to reschedule any appointment for you. We do request Twenty-four (24) hour notice of cancellation. It is our aim to accommodate you the patient. We have patients eager to use your cancelled appointment time. We reserve the right to charge a cancellation fee for appointments not cancelled 24 hours in advance. We hope you, our valued patient, will cooperate in this simple request.

SKIN EXAMINATION: I understand that in order for the doctor to give me the best medical care possible, I must follow instructions and notify the office if I have problems with my medications or treatment. Please answer the following choices:
Complete Skin Examinations:

- I wish to have a complete skin examination, if time allows
- I wish to have a complete skin examination, at a later date
- I do not wish to have a complete skin examination

FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

MEDICARE ASSIGNMENT OF BENEFITS (PERTAINS TO ALL MEDICARE RECIPIENTS ONLY)

I authorize payment to be made to HD. I authorize any holder of medical information about me to my insurance carrier and or HCFA and its agents and/or my Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

INSURANCE LEGAL ASSIGNMENT OF BENEFITS

I acknowledge that as a courtesy HD will file a claim on my behalf. I authorize payment to be made to HD. I authorize any holder of medical information about me to my insurance carrier any information needed to determine these benefits or the benefits payable for related services. I hereby authorize HD to give my insurance company all information concerning every condition for which I have been under observation or treatment, the history obtained, physical and laboratory findings, diagnosis and treatment. I authorize payment of medical benefits to the physician for services rendered. **I also understand that if any charges are not covered by my insurance carrier or my insurance benefits are terminated, I will be responsible for payment of all charges.**

FOR PATIENTS WITH NO INSURANCE COVERAGE: I acknowledge I am financially responsible for all charges for services and payment is expected at the time of service unless other arrangements have been made in advance for a payment plan.



2950 Keewahdin Road
Fort Gratiot, MI 48059
Ph: (810) 455-1600
Fax: (810) 455-1620



285 North Lilley Rd
Canton, MI 48187
Ph: (734) 495-1506
Fax: (734) 495-1780



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RELEASE TO LEAVE CONFIDENTIAL MESSAGES (APPOINTMENT REMINDERS, DIAGNOSTIC TEST

RESULTS): I hereby authorize HD to leave confidential messages on my telephone answering machine or voicemail. I am authorizing the following telephone numbers to be used for the authorized calls or other health care information if other than home telephone number(s): _____

**I am fully aware that a cell phone is not a secure and private line.*

In signing this notice, I, _____ am granting permission for this office to inquire or obtain information from my insurance company for treatment and billing purposes for myself and family members and to receive and/or forward necessary records if indicated in the case of a referral or transfer to another facility.

Please list the family members or other persons, if any, whom we may inform about your medical condition (including treatment and payment).

NAME	RELATIONSHIP

Please list the family member who is named legal representative (guardianship, foster care or medical power of attorney), whom we may inform and/or inquire about your medical condition given more **extenuating** circumstances: _____

Contact number: _____

ACKNOWLEDGEMENT OF REVIEW: PRIVACY PRACTICES: I understand that I am entitled to receive a copy of the Notice of Privacy Practices. I am aware that I am entitled to review Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I hereby authorize HD to release any information in the course of my examination or treatment as needed to process my insurance claims and to inform my private physician as to my course of treatment.

I CERTIFY THAT I HAVE READ THIS FORM AND UNDERSTAND THE CONTENTS OF THIS FORM.

PATIENT NAME: _____
(Please Print)

DATE OF BIRTH: _____

SIGNATURE OF PATIENT (OR OTHER LEGALLY AUTHORIZED PERSON):

DATE:

PRINTED PATIENT NAME OF LEGALLY AUTHORIZED PERSON:



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