TREATMENT AGREEMENT

1. CONSENT TO TREATMENT

I hereby voluntarily request, consent to and authorize Mid Michigan Sleep & Asthma Center and its associates, employee(s), assistants, or other practitioners under their orders to treat me (my minor child) at MMSAC office, and to provide medical treatment including, but not limited to, diagnostic procedures, x-rays, and administration of medications, as is deemed necessary and advisable. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments and examination in MMSAC office.

2. PATIENT'S PERSONAL POSSESSIONS

MMSAC is not responsible for any patient's clothing, valuables, or other personal belongings left with/by the patient. I hereby release MMSAC from any liability for any and all personal possessions which I choose to keep with me during my office visit.

3. VIDEO TAPPING AND PHOTO RELEASE

I hereby authorize MMSAC to use my likeness in either Video or Photo form for the purpose of Teaching, Advertising or in Medical records.

4. RELEASE OF INFORMATION

I hereby authorize MMSAC, or her designee, to release information, in written form, by phone, or facsimile machine, contained in the patient's medical records. I specifically authorize the release of drug and alcohol abuse records in accordance with the Federal Regulations and/or communications made by me to a social worker or psychologist and/or records pertaining to communicable diseases.

5. ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign, transfer, and set over unto Mid Michigan Sleep & Asthma Center as its interest may appear all benefits now due or becoming due to me by virtue of the present office treatment.

6. AGREEMENT TO PAY FOR SERVICES

I understand that I am liable and responsible for any health insurance deductibles and coinsurance portions of my bill. I also understand that I am responsible to pay for all services to be rendered to the patient whether signing as agent or as patient.

The undersigned certifies that (s)he has read the forgoing or that it has been read to him/her, and that (s)he understands the same and consents thereto, and that (s)he is the patient or the duly authorized representative or agent of the patient to sign the form and consent thereto.

I further understand that my treatment may require more than one occasion or service; therefore, this consent shall carry full force and effect from the date of signature until I am discharged from further treatment.

DATE: _____ _____

NAME OF PATIENT

_____

(Signature of Patient or Legal Representative)

_____ _____

(Signature of Witness) (Relationship, if other than parent)

If patient is unable to sign, or is a minor, complete the following:

Patient is (a minor ____ years of age) or is unable to sign because: _____