West Michigan Endocrine
15060 Cascade Road, Suite C1
Grand Rapids, MI 49546
P: 616.255.9521 F: 616.255.9627
contact@westmichiganendocrine.com

GENERAL CONSENT TO TREAT FORM

I have the legal right to consent to medical treatment because (a) I am the patient or (b) I am the patient's legal representative. If you are the legal representative, please state your relationship to the patient. _____

All references to "patient", "me" and "my" in this document refers to: _____.

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the doctors at West Michigan Endocrine and their designated associates or assistants believe are necessary. I also consent to the taking of photographs or films related to the care and treatment of the patient and understand that such photographs or films may be made part of the medical record. I understand that by signing this form, I am giving permission to the doctors, nurses, medical assistance, medical students, and medical residents in this medical office to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent. I am aware the practice of medicine is not an exact science. No guarantees have been made to me as a result of my treatment or examination at West Michigan Endocrine.

_____ (**Please initial**)

CONSENT TO CONTACT

I have given residential and/or cellular telephone numbers and/or an email address to West Michigan Endocrine. I consent to receive calls, voicemail messages, and emails from West Michigan Endocrine. These communications may include issues about billing. Please let us know if you do not want us to leave voicemail messages. I can still be treated even if I do not give "consent to contact".

_____ (**Please initial**)

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I acknowledge receiving West Michigan Endocrine's Financial Policy. This Policy explains my financial responsibility and how any past due balances will be handled. This policy can be found on our website or you can request a copy of the policy at the front desk. If you have questions please contact our Office Manager at 616 255-9521.

_____ (**Please initial**)

ACKNOWLEDGEMENT OF OFFICE POLICY

I acknowledge receiving West Michigan Endocrine's Office Policy. By acknowledging this I am accepting the policy as stated. I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it. This policy can be found on our website or you can request a copy of the policy at the front desk. If you have questions please contact our Office Manager at 616 255-9521.

_____ (**Please initial**)

Signature of Patient or Patient's Legal Representative:

_____ Date: _____

This consent is valid for three (3) years from the date of my signature.