NOVELLO INFUSION
Healthcare Reimagined.

CONSENT AND AUTHORIZATION

1. GENERAL CONSENT TO TREAT

I, the undersigned, hereby voluntarily request consent to and authorize all medical care, including physical examination and screening, diagnostic procedures, and drug administration as deemed necessary by the attending physician(s), or other medical staff members and health care providers of Novello. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me with respect to the results of the care and treatment that I have received.

2. HIPAA (Health Insurance Portability and Accountability Act)

I have been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most recent copy of this notice.
Initials: _____

3. CONSENT FOR EXPOSURE TESTING

I understand that if a healthcare professional, or other health facility employee, is exposed to my blood or body fluid, that testing, including but not limited to: HIV, Hepatitis B or Hepatitis C may be performed without my consent, as mandated by MCL 333.20191.

4. RELEASE OF MEDICAL INFORMATION

I understand that the facility may disclose all or any minimally necessary portion of my patient medical record information to: attending physicians, consulting physicians, nurses, pharmacists, technicians, medical students, and other healthcare providers. This includes people or entities not employed by the facility who have a legitimate need for this protected health information (PHI) for my care and continued treatment.

5. RELEASE OF INFORMATION FOR INSURANCE

I authorize Novello Infusion to release to any third-party payer, or its representative, including Medicare, Medicaid, Champus, Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, workers' disability compensation insurers, employers, health maintenance organizations, preferred provider organizations and managed care plans, which may be responsible for payment in my case, or as required by law, such information from my medical record as is necessary in order to receive reimbursement for any billings rendered relating to my treatment.

6. RELEASE OF INFORMATION FOR PUBLIC HEALTH

I authorize Novello Infusion to release information contained in my medical record, including information about communicable diseases and/or infections, as defined by Michigan statute and Department of Public Health rules, which include Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), venereal disease and tuberculosis, and alcohol and/or drug abuse information protected under the regulations in 42 Code of the Federal Regulations part 2, psychiatric/psychological records, and social work records, including communications to a social worker, psychiatrist or psychologist.

7. FINANCIAL RESPONSIBILITY

I assign and authorize direct payment to Novello Infusion of all health benefits, and other forms of payment relating to the care provided to me. I assume full financial responsibility for payment of all expenses associated with my care and treatment, including any charges not paid by insurance.

*Please note that if you are paying cash for this exam, we will not bill your insurance and the cash price may not be applied to your deductible. *

(Continued on back)

8. TELEPHONE CONSUMER PROTECTION ACT

I understand that Novello Infusion may contact me to (1) discuss any past, current, or future services provided by Novello, as permitted under HIPPA; (2) discuss the accounting, billing, or other financial information (such as insurance information and service fees) for past, current, or future services provided by Novello and (3) discuss collections of any past due amounts. I consent and agree Novello Infusion may contact me via call, text, or email. I agree to Novello sharing my contact information with service providers (including a collection agency), but I understand that Novello will not share my phone number with third parties for their own purposes without my consent. I Hereby expressly consent to and further knowingly provide my mobile or other telephone number and any subsequent change in contact numbers or other means of communication, including but not limited to, text messages, or electronic mail at the address provided by me to Novello Infusion as a means to receive communication including those using automated dialing systems and/or an artificial or prerecorded voice, which may include, but are not limited to, appointment reminders, reminders to schedule wellness exams or other preventative services, payment-related messages, patient satisfaction surveys, and to receive information about the availability of new services. . I understand that standard telephone minute and text charges may apply.

9. RELEASE OF RESPONSIBILITY: PERSONAL VALUABLES

I understand that Novello Infusion is not liable for the loss or damage to any personal property that I choose to keep with me during my visit, and that I am responsible to make arrangements to keep items of value secured.

10. ADVERSE REACTION

I understand that contrast media may be used for my exam (Iodine, or Gadolinium-based). Most patients experience no unusual effects from this injection. Some may experience minor reactions including nausea/vomiting, headache, and sneezing. A small number may have a mild allergic-type reaction such as hives or swelling of the eyes and lips. Serious or life-threatening reactions are extremely rare. Patients with reduced kidney (renal) function or kidney failure should not undergo an injecting unless it has been cleared by a specialist. It has been shown that gadolinium agents can be retained in areas of the body, such as brain, or in bone. The importance of this is unclear, and no disease process has been associated, even in cases where deposits have been found. The lowest retention has been shown with the type of agents (macrocyclic) used at our office. Your doctor is aware of these possible complications but has determined that the additional diagnostic information provided by the contrast outweighs the minimal risks of this procedure. I give permission for the scan to be performed and for the contrast material to be used if necessary.
Initials: _____

I certify that I have read this consent form, or that it has been read to me. I understand its contents and agree that by signing this form I am bound by its provisions, whether signed by myself or a representative acting on my behalf.

Patient Signature_____Date/Time_____
(Parent/Guardian, if minor, or person signing on patient's behalf)

Relationship if other than patient_____

Witness_____

Date/Time_____