General Consent Form

Angela Bully, M.D. **Tammie L. Bully, M.D.**

Patient Name ____ Date ______________

Social Security Number ____

1. I hereby do voluntarily consent to such care including routine procedures, examinations tests, immunizations, vaccinations, regional or local anesthesia and other treatment by Dr. Bully or her assistants as is necessary in their judgment.

2. If I don’t fully understand a procedure or its risk, consequences and alternate methods of treatment, I have the right to question the appropriate health care professional.

3. I realize that Dr. Bully’s practice site may include teaching medical students and that some procedures may be performed by students under the supervision of Dr. Bully.

4. I understand that blood may be drawn from me for HIV testing without further permission being given by me if a doctor, or other health professional or employee is exposed to my blood or bodily fluids.

5. I understand that Dr. Bully shall not be responsible or liable for the loss of/or damage to any personal property.

6. I authorize the release to Dr. Bully such information from my records as is required in order for Dr. Bully and all entities providing services to obtain payment. This includes records of alcohol and drug abuse and /or treatment, records indicating testing, diagnosis or treatment of HIV infections, or any other related condition, records of psychological services and social services, including communications made by the patient to the physician, social worker, or psychologist. This authorization shall be effective only so long as necessary to obtain payment or reimbursement and will end when payment or reimbursement is received.

7. I authorize Dr. Bully to review my insurance coverage with my insurance company.

8. I authorize payment of insurance benefits to be made directly to Dr. Bully.

9. I permit a copy of this authorization to be used in place of the original if necessary.

I have read this form and my questions have been adequately answered and I certify that I understand its contents.

SIGNATURE OF PATIENT: ____

SIGNATURE OF WITNESS: ____

SIGNATURE OF PARENT OR GUARDIAN: ____