BELLEVILLE LAKE PEDIATRICS
CONSENT FOR MEDICAL TREATMENT

This form is a general consent for routine pediatric outpatient care provided by Belleville Lake Pediatrics. A separate, specific informed consent will be obtained before any procedure, sedation, or other higher-risk treatment, as required by law or practice policy.

PATIENT INFORMATION

Patient Full Name: _____

Date of Birth: ____ / ____ / _____

Parent/Guardian Name (if patient is a minor): _____

Relationship to Patient: _____

Telephone Number: _____

NATURE OF TREATMENT

I understand that the patient's healthcare providers (physicians, nurse practitioners, physician assistants, nurses, and other staff acting under their supervision) may:

- Examine the patient and review the patient's medical history
- Order tests, procedures, or treatments as medically appropriate
- Provide medications, injections, or other therapies as needed
- Refer the patient to specialists when necessary
- Provide preventive care services (such as screenings and vaccinations)
- Explain significant proposed treatments, including their risks, benefits, and alternatives, and answer questions before they are given

RISKS OF MEDICAL TREATMENT

I understand that medical treatment of the patient may involve risks including, but not limited to:

- Allergic reactions to medications
- Side effects from medications or treatments
- Infection at injection or procedure sites
- Pain, bruising, or discomfort
- Unexpected reactions to treatments
- Rare but serious complications
- Failure of treatment to achieve desired results
- Discovery of previously unknown conditions during examination

ALTERNATIVE TREATMENTS

I understand that alternatives to proposed treatments for the patient may include:

- Different medications or therapies
- Referral to specialists
- Observation without immediate treatment
- Seeking care elsewhere and second opinions

NO GUARANTEE OF RESULTS

I understand that, with respect to the patient's care:

- No guarantee has been made regarding the outcome of the patient's treatment
- Medicine is not an exact science
- Complications may occur despite appropriate care
- Additional treatment may be necessary

PATIENT RESPONSIBILITIES

I (or my child, as appropriate) agree to:

- Provide (or, if the patient is a minor, have the parent or legal guardian provide) accurate and complete medical history
- Inform the patient's provider of all of the patient's current prescription and over-the-counter medications, supplements, and allergies
- Follow treatment instructions and recommendations
- Keep scheduled appointments or provide reasonable notice of cancellation in accordance with the practice's cancellation policy
- Ask questions if I do not understand something
- Inform the patient's provider of any changes in the patient's condition
- Inform the practice of any custody orders, guardianship, or changes in who has legal authority to consent for the minor
- Inform the practice of changes in contact information or insurance

CARE WHEN ANOTHER ADULT ACCOMPANIES MY CHILD

I understand that I may designate other adults who are authorized to accompany my child to appointments and consent to routine medical care on my behalf, limited to routine examinations, sick visits, and immunizations. This authorization does not extend to procedures, sedation, or other non-routine treatment unless I separately authorize such care in writing. My child's providers may contact me directly when they determine it is appropriate. Each authorized adult must present valid photo identification at each visit. This authorization remains in effect until I revoke it in writing or until one (1) year from the date of signature, whichever occurs first. I understand that a longer-term or broader delegation of my parental authority may require a written delegation of parental powers by power of attorney under MCL 700.5103, which is limited to a period of not more than six (6) months.

I understand that Michigan law permits a minor to consent on his or her own to certain services, including testing and treatment for sexually transmitted infections and HIV and pregnancy-related and prenatal care (MCL 333.5127), substance use disorder services (MCL 333.6121), and, for minors fourteen (14) years of age or older, outpatient mental health services (MCL 330.1707). These services are handled confidentially and will not be shared with authorized adults, and will be disclosed to a parent or guardian only as permitted or required by law.

Authorized Adult(s) for Routine Care Only (Optional)

Name	Relationship	Telephone

PRIVACY AND CONFIDENTIALITY

I acknowledge that I have been offered and/or received a copy of the Notice of Privacy Practices explaining how my health information may be used and disclosed. I understand that health information will be handled in accordance with HIPAA and applicable Michigan law.

CLINICAL PHOTOGRAPHS

Photographs may be useful for documenting medical conditions, monitoring changes, and supporting clinical care. Any photographs obtained for these purposes will be maintained exclusively as part of the patient's medical record and will not be disclosed except as permitted by law for treatment, payment, or healthcare operations, and will not be used for marketing or promotional purposes without separate authorization.

I consent to the taking of clinical photographs of the patient for documentation, monitoring, and clinical care, to be maintained as part of the patient's medical record, unless I check the box below.

☐ I do not consent to clinical photographs

COMMUNICATION AUTHORIZATION

I authorize Belleville Lake Pediatrics to communicate with me (or, if the patient is a minor, with the parent/guardian signing below) regarding appointments, treatment, test results, billing matters, and other healthcare-related information by (check all that apply):

- ☐ Telephone
- ☐ Voicemail (detailed messages permitted)
- ☐ Text Message
- ☐ Email
- ☐ Patient portal

Preferred Telephone Number (circle one: Patient / Parent/Guardian):

_____

Preferred Email Address (circle one: Patient / Parent/Guardian):

_____

I understand that unencrypted email and text messages are not secure and carry a risk that health information may be intercepted, misdirected, or viewed by others, and I accept that risk for any such channel I have selected. Standard message and data rates may apply to text messages.

Email, text message, and patient portal messages are not monitored for emergencies and must not be used for urgent matters. In an emergency, call 911.

I may change or revoke this communication authorization at any time by notifying Belleville Lake Pediatrics; any change will not affect communications already sent.

EMERGENCY SITUATIONS

I understand that in medical emergencies, the patient's healthcare provider may provide necessary treatment or arrange for necessary treatment without prior consent when one or more of the following applies, to the extent permitted by law:

- Immediate treatment is necessary to prevent death or serious harm to the patient
- The patient is unable to consent and/or the parent, legal guardian, or other authorized representative cannot be reached in time
- Emergency treatment is otherwise permitted by law

I understand that this practice is an outpatient medical office and is not equipped to provide emergency or hospital-level care. In an emergency, office staff may call 911 and arrange for transfer of the patient to an appropriate emergency facility, and will make reasonable efforts to contact the patient's parent, legal guardian, or other authorized representative as soon as practicable.

PATIENT ACKNOWLEDGMENT AND CONSENT

I acknowledge that:

- I am the patient (18 or older, or an emancipated minor) or the parent/legal guardian with legal authority to consent for the minor patient, and I will provide documentation on request
- I have read and understand this consent form
- My questions have been answered to my satisfaction
- I had the opportunity to have this form explained in a language I understand
- I understand the general nature of the medical treatment to be provided to me (or my child) and its risks
- I understand my rights and responsibilities as a patient (or as the parent/legal guardian of a minor patient), including the right to ask questions and the right to refuse specific recommended treatments
- I voluntarily consent to medical treatment for myself (or my child) by Belleville Lake Pediatrics
- This consent remains in effect for ongoing care until revoked
- I may withdraw this consent at any time by providing written notice; withdrawal will not affect treatment already provided or actions taken in reliance on this consent

SIGNATURES

Patient (If 18 Years of Age or Older or an Emancipated Minor)

Signature: _____

Printed Name: _____

Date: ____ / ____ / _____

Parent or Legal Guardian (If Patient Is Under 18)

Signature: _____

Printed Name: _____

Relationship to Patient: _____

Legal Authority: □ Parent □ Court-appointed guardian □ Delegated authority (attach documentation) □ Other: _____

Date: ____ / ____ / _____

Witness / Office Representative

Signature: _____

Printed Name: _____

Title/Position: _____

Date: ____ / ____ / _____