OAKLAND COLON AND RECTAL ASSOCIATES, P.C *Diseases of the Colon and Rectum*

DONALD C. BARKEL M.D., P.C.
HARRY J. WASVARY M.D., P.C
JASON SHELLNUT M.D., P.C.
MATTHEW ZIEGLER M.D.
CLAIRE PEEPLES, M.D.
STEPHEN G. PRIEST, M.D.

1121 CROOKS ROAD
ROYAL OAK, MICHIGAN 48067
PHONE: 248-541-8554
FAX: 248-541-1791
WWW.OAKLANDCOLON.COM

GENERAL CONSENT TO TREATMENT

I request and authorize medical or surgical treatment as may be deemed necessary and appropriate by the physician and his/her designees and assistants participating in my care.

I also assign and authorize payment from my insurance company to the physician at Oakland Colon & Rectal Associates, P.C., for any and all services rendered. I agree to pay any charges not covered by my insurance company, or pay in full if I have no insurance coverage.

I have read this form or it has been read to me and I am satisfied that I understand its contents. I further understand that this consent will be deemed continuing and I am free to withdraw my consent at any time. I also understand that co-payments and deductibles are payable at the time of service.

_____ X_____
Date Signature of patient or guardian

_____
Signature of witness

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered and/or received a copy of Oakland Colon & Rectal Associates, P.C., a Notice of Privacy Practices.

_____ X_____
Date Signature of patient or guardian

If there are specific persons you would want us to discuss your medical information and/or treatment with, please list their names below. Written authorization is required.

_____ _____

_____ _____

_____ _____