24 HR Lifeline MD
Urgent Care and Family Medicine
12640 Twelve Mile Rd, Warren, MI 48093
586-751-2020 Main
586-745-1756 Fax

INFORMED CONSENT AND UNDERSTANDING

1. I _____(patient name) give permission for **24 HR Lifeline MD** to provide me medical treatment.

2. I allow **24 HR Lifeline MD** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - **24 HR Lifeline MD** will have to send my medical record information to my insurance company.
   - I understand that there may be non-covered benefits or deductibles requiring fulfillment per my insurance plan which I may be responsible for as outlined in my financial responsibility agreement.
   - I agree to assume cost of these potential non-covered services if my insurance does not cover the services or if I do not have insurance in which I agree to pay for any services received or provided at patient visit.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

_____ _____
Patient's signature Date

_____ _____
Parent or guardian signature Date
(for children under 18)

_____
Print name