

Request for Provision of Medical Services to include: **Examination &/or Laboratory Testing,  
Acknowledgment of Receipt of Notice of Health Information Privacy Practices**

Client Name \_\_\_\_\_ Chart # \_\_\_\_\_

**Before you give consent, be sure you understand the information we have given you. If you have any questions as you read, we will be happy to discuss them with you. Remember that your consent is entirely voluntary. You may ask for a copy of this form.**

I hereby request that a person authorized by the Wellness Center of Door County, Inc. examine me, on one of more occasions, and perform any laboratory tests that may be necessary as part of my examination and treatment. I understand that I will be informed of the nature and purpose of any examination and tests required before they are performed. I also understand that I will be given an opportunity to ask any questions I might have and that a clinician is available to answer my questions. I realize that I may refuse any tests that I do not wish to have performed.

I realize that if tests are taken for sexually transmitted infections, reporting of certain positive results to public health agencies is required by law and that I may be asked to volunteer the names of recent sexual contacts.

I release the Wellness Center of Door County, Inc. and its medical staff from any and all liability arising out of or connected with erroneous test results from an outside laboratory, particularly with regard to any errors in diagnosis based on these erroneous results.

I understand that referral will be made for further diagnosis and/or treatment where indicated. I understand that if follow-up is needed, I will assume the responsibility for such follow-up. I have been told how to get this care in case of a medical emergency.

I hereby give my permission to the employees of the Wellness Center of Door County, Inc. and others authorized by them to use the information contained in my medical record for statistical purposes, with the understanding that confidentiality will be maintained.

**I hereby acknowledge receipt of Wellness Center of Door County's notice of health information privacy practices.** (Wellness Center's Health Information Privacy Practices -HIPPA- are found in white binders in waiting room area, copies are available upon request).

I understand that I am financially responsible to the Wellness Center of Door County and I expressly promise and agree to pay the Wellness Center for all such charges which are not paid by either my insurance plan, HMO, PPO or other coverage if applicable, in addition to co-payments and deductible charges for services that are not covered by the Medicaid or Medicare programs. Assignment is valid for one year.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

I witness the fact that the client received the above information and said she/he read and understood it same and had the opportunity to ask questions.

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

1/4/06