CARLS CENTER FOR CLINICAL CARE AND EDUCATION

CENTRAL MICHIGAN UNIVERSITY

Patient Name: _____ Date of Birth: _____

MR#_____
(For office use only)

CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

My signature below gives the Carls Center for Clinical Care and Education my consent for treatment and authorizes the release of any medical information necessary to process insurance claims on my behalf and/or my family members. Payment for medical services will be made directly to the Carls Center for Clinical Care and Education. I understand that I am financially responsible for any and all charges not covered by this assignment. Any past due accounts are referred to ***CBM***, a collection agency. If an account is sent to collections, the patient will be responsible for all fees associated with collecting this debt, such as litigation and attorney fees. Once the account has been referred to the collection agency, it will be reported to the national credit bureaus.

_____ **Date:** _____

Signature: Patient, Parent or Guardian

Printed Name of Above Signature: _____

Relationship to Patient: _____

INFORMED CONSENT

Central Michigan University's Carls Center for Clinical Care and Education has two purposes. It is responsible for providing clinical education and training for students in the College of Health Professions while providing the best possible **assessments** and **treatment** services to clients and families participating in its clinical programs. Clinical supervisors and students are required to directly and indirectly observe assessment and treatment sessions. Audio taping and/or videotaping for assessment and treatment purposes, and using medical records for quality assurance review purposes are necessary and required.

By signing below, you are granting consent to the above required clinical service conditions.

_____ **Date:** _____

Signature: Patient, Parent or Guardian

I also consent to the use of medical record data (including treatment outcomes data, as well as audio and/or video tapes) for classroom teaching purposes.

(Please mark one) **YES** ☐ **NO** ☐ **Patient/Parent/Guardian's Initials:** _____

CONSENT FOR RESEARCH NOTIFICATION

In addition to providing clinical services and educating professionals, CMU's Carls Center for Clinical Care and Education also conducts research in an attempt to improve the quality of care and service or gather information regarding procedures, tests and clinical equipment. The research may be done by a faculty member, a clinical supervisor or a graduate student under the supervision of a faculty member or clinical supervisor. If you are interested in participating in a research project your consent is required so we may contact you. If contacted, you would be informed of the nature of the project and could make a decision about participation at that time. The quality of your clinical care will not be affected by your decision to participate and you may refuse participation at any time.

May we contact you regarding possible participation in research projects? (please mark one) **YES** ☐ **NO** ☐

_____ **Date:** _____

Signature: Patient, Parent or Guardian