GENERAL CONSENT TO TREATMENT

Rivkin Addiction Medicine, PLLC

Aaron Rivkin, MD • 19100 Goddard Road, Suite 1, Allen Park, MI 48101

Patient Name	_____
Date of Birth	_____
Date of Consent	_____
Treating Physician	Aaron Rivkin, MD

This form provides your general consent to treatment and authorizes the use and sharing of your health information for your care. Please read each section carefully. You may ask questions at any time. Signing this form is voluntary — you will not be denied treatment for declining any section. You may revoke any consent in writing at any time.

1. CONSENT TO EVALUATION AND TREATMENT

I consent to evaluation, diagnosis, and treatment by Aaron Rivkin, MD and Rivkin Addiction Medicine, PLLC. I understand that treatment may include clinical assessment, medication management, laboratory testing (including urine drug screening), care coordination, referrals, and other evidence-based addiction medicine services.

I understand that my provider will explain my diagnosis, treatment options, and any medications prescribed to me, and that I have the right to ask questions and to decline any specific treatment at any time.

2. CONSENT TO TELEHEALTH SERVICES

I understand that Rivkin Addiction Medicine, PLLC offers services via telehealth (video visits) using a HIPAA-compliant platform. Telehealth visits are subject to the same clinical standards as in-person visits. I understand that telehealth has certain limitations, including inability to perform physical examinations and the possibility of technology failure. I understand that I must be physically located in Michigan during all telehealth visits.

3. CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA)

I have received and reviewed the Notice of Privacy Practices for Rivkin Addiction Medicine, PLLC. I understand how my health information may be used and disclosed for treatment, payment, and healthcare operations as described in that Notice.

I consent to the use and disclosure of my protected health information (PHI) for the following purposes:

- Treatment: Sharing my records with other providers involved in my care, including my primary care physician, specialists, pharmacies, and hospitals
- Payment: Submitting claims to Medicare, Medicaid, and commercial insurers; responding to billing inquiries from payers
- Healthcare operations: Quality assurance, compliance activities, and administrative functions of this practice
- Care coordination: Sending or receiving records to facilitate transitions of care, referrals, and continuity of treatment

4. CONSENT TO DOCUMENTATION AND DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS (42 CFR PART 2)

PLEASE READ THIS SECTION CAREFULLY. This section relates to special federal protections that apply specifically to your substance use disorder (SUD) treatment records.

Federal law (42 CFR Part 2) provides special protections for records related to your substance use disorder diagnosis, treatment, or referral. These records receive stronger privacy protections than standard medical records under HIPAA. Normally, your SUD records cannot be shared outside this practice without a separate written authorization from you each time.

By signing below, you are consenting to two specific things:

1. EHR Documentation: You consent to Aaron Rivkin, MD documenting your SUD diagnosis, treatment, and related clinical notes, billing records, and care coordination information in Elation Health (our electronic health record system). This documentation is necessary to provide you with ongoing care and to process your insurance claims.

2. Communication with Your Care Team: You consent to Aaron Rivkin, MD discussing your SUD treatment — including your diagnosis, medications, and progress — with your primary care physician and any specialists involved in your care, when clinically relevant to your treatment. This allows your providers to coordinate your care safely and effectively.

What this consent does NOT cover:

- Disclosure to law enforcement, prosecutors, or courts — those require a court order under 42 CFR Part 2 regardless of this consent
- Disclosure to your employer or any entity for employment purposes
- Disclosure to any provider not involved in your direct care
- Any disclosure not specifically described above — those require a separate signed authorization from you

Your rights:

- Signing this consent is voluntary. You will not be denied treatment if you decline.
- This consent remains in effect until you revoke it in writing. Revocation will not affect disclosures already made in reliance on this consent.
- Even with this consent, recipients of your records are prohibited from re-disclosing your SUD records beyond the purposes stated here without your written consent or a court order.

5. FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for all charges incurred at Rivkin Addiction Medicine, PLLC, including any amounts not covered by my insurance. I authorize this practice to bill Medicare, Medicaid (Healthy Michigan Plan), and/or my commercial insurer on my behalf.

I assign my insurance benefits directly to Rivkin Addiction Medicine, PLLC for services rendered. I authorize the release of any health information necessary to process insurance claims. I understand that my insurance coverage does not guarantee payment, and that I am responsible for any deductibles, copays, coinsurance, and non-covered services.

6. CONSENT TO EMERGENCY TREATMENT

In the event of a medical emergency in which I am unable to provide consent, I authorize Rivkin Addiction Medicine, PLLC to provide or arrange for emergency medical treatment as deemed necessary by the treating provider. This practice will make reasonable efforts to contact me or my emergency contact prior to treatment when feasible.

Emergency Contact Name: _____	Relationship: _____	Phone: _____ _

7. SIGNATURE

By signing below, I confirm that I have read this General Consent to Treatment, had the opportunity to ask questions, and understand and agree to its terms. I understand that I may revoke any consent granted here in writing at any time.

Patient Signature	**Guardian / Representative (if applicable)**
X _____ _____	X _____ _____
Printed Name: _____	Printed Name: _____
Date: _____	Relationship: _____
	Date: _____

If patient was unable to sign, document reason:

Reason: _____ Staff Initials: _____