

McLaren Print System Order

Order No: 61632
Order Date: 2021-04-09
User: Tammy Sagamang
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Ship Location: McLaren Int. Med. Res. Group Practice-Attn: Tammy
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Forms

Quantity: 1000
Paragon Dept No: 60030
Dept Name: McLaren Int. Med. Res. Group Practice
Company Number: 60

Order Total Price: 0.00

Item Number: 17451
Item Description: Consent for Treatment / Financial Authorization
Revision Date: 3/2015
Print: 2 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLAREN PRINT
CONSENT FOR TREATMENT-FINANCIAL AUTHORIZATION

1. I understand that I have a condition requiring treatment and do hereby voluntarily consent to such routine diagnostic procedures, hospital care and medical treatment (including the administration of drugs and routine therapeutic) as deemed necessary or advisable by the physicians who treat me, their assistants or designees and hospital employees.

I understand that I have a right to consent or refuse to consent to any proposed procedure or therapeutic course during my episode of care.

I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risk of injury, or even death. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this hospital.

I understand that the physicians at this hospital may not be employees or agents of the hospital, but, rather may be independent contractors who have been hired to provide medical treatment. Further, I realize that among those who may attend to me at this hospital are medical, nursing and other health care personnel in training who, unless requested otherwise, may participate in patient care as a part of their education.

2. I agree that specimens of blood, urine and other bodily fluids, tissues or products may be taken and that routine diagnostic tests may be performed on these specimens per the physician's order. I understand that in rare instances a person-to-person exposure may occur. If another person has a percutaneous, mucus membrane, open wound, or other exposure to my blood or other body fluids, the hospital may perform but not be limited to the following tests: an HIV, hepatitis screens, and other blood borne pathogen tests as needed, without any additional consent.

NOTICE: The hospital may perform an HIV test upon me without any additional written consent, as stated in ACT 499 P.A. 1998, if a health professional or employee at the hospital has a percutaneous, mucus membrane, or open wound exposure to my blood or other body fluids.

3. I recognize that the Hospital/Clinic may release information from my medical record including: information about communicable diseases and serious communicable diseases and infections as defined by statute and Michigan Department of Public Health rules (which include Varicella Disease, Tuberculosis, Hepatitis B, Human Immunodeficiency virus, Acquired Immunodeficiency Syndrome and Aids related complex); substance abuse treatment information protected by 42 Code of Federal Regulations Part 2; psychological and social services information including communications made by me to a psychologist or social worker to:

- a) any third party payor, or insurance company or other individual who may be responsible in whole or in part for paying my hospital bill so that the Hospital/Clinic may be paid for its services, and any independent auditors/reviewers retained by any third party payor, private health insurers or any employer providing health benefits to me so that these independent auditors can analyze Hospital/Clinic charges as is necessary to obtain payment for the services and required review or audit of that payment by the payor.
- b) any health care facility or physician to which I am referred for continuity of care.

With respect to substance abuse information (if any), this consent may be revoked at any time, unless the Hospital/Clinic has already released information in reliance upon it, or if payment for services rendered would be interrupted by such revocation.

Spec Info:

