McLaren Business Products

McLaren Print System Order

Order No: 6219
Order Date: 2014-10-02
User: Judy Fago
Phone: 586-493-3610

Ship Location: Judy Fago
36500 Gratiot, Suite 102
Clinton Township, MI 48035
Forms
Quantity: 2500
Paragon Dept No: 0573
Dept Name: Multi-Specialty Clinic
Company Number: 260

Order Total Price: 0.00

Form Number: MM-17469-A
Form Description: Consent for Treatment / Financial Authorization
Revision Date: 9/2014
Print:
Paper:
Size:
Fold:
Finish:
Drill:

McLaren Macomb
CONSENT FOR TREATMENT/FINANCIAL AUTHORIZATION

1. I hereby voluntarily request, consent to and authorize the physician, his/her associates, assistants or other practitioners to provide medical and minor surgical treatment, including but not limited to diagnostic procedures, x-rays, medication administration, physical examination and screening services, including drug/alcohol screening, as is deemed necessary and advisable. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examination and treatment which I have hereby authorized.
2. I authorize McLaren Health Care Corporation and its affiliates to release to any third party payer, or its representative, including Medicare, Medicaid, Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, workers' disability compensation insurers, employers, health maintenance organizations, preferred provider organizations and managed care plans, which may be responsible for payment in my case, or as required by law, such information from my medical record as is necessary in order to receive reimbursement for any billings rendered relating to my treatment, including alcohol and drug abuse records protected under the regulations in 42 CFR, Part 2, if any, and social services records, if any, and psychological service records including communications by me to a social worker or psychologist. I also authorize McLaren Health Care Corporation and its affiliates to release to individuals or agencies which may provide services for my care such information from my medical record as is necessary to provide those services. I also authorize release of information to any independent auditors or reviewers retained by any third party payer, private health insurers, or any employer providing health insurance benefits to me so that these independent auditors can analyze charges.
3. I further understand that my treatment may require more than one date of service, therefore this consent shall carry full force and effect from the date of signature until I am discharged from treatment; I understand that treatment may be rendered at McLaren Macomb or other McLaren facilities.
4. I hereby assign payment directly to McLaren Health Care Corporation and its affiliates of the insurance benefits otherwise payable to me but not to exceed the balance due to McLaren Health Care Corporation and its affiliates for charges for these services.
5. I assume full financial responsibility for payment of all services provided to me, including any portion of my bill that is not paid by insurance, workers' disability compensation or social agencies.
6. I understand the content and significance of this form, and my questions have been answered.

****** NOTICE ******

If another person has a percutaneous, mucous membrane, or open wound exposure to my blood or other body fluids, the McLaren Macomb 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.

Public Act No. 488 of 1988 of the State of Michigan states that an HIV test may be performed upon me without any additional consent, if a health professional or employee has a percutaneous, mucous membrane, or open wound exposure to my blood or other body fluids.

Signature of Patient/Patient Representative Relationship Date Witness

Telephone consent obtained from: Witness

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have received McLaren Health Care's Notice of Privacy Practices.

Signature (Patient/Patient Representative) Date

Printed (Patient/Patient Representative) Date

CONSENT FOR TREATMENT/FINANCIAL AUTHORIZATION