BARBARA ANN Karmanos
CANCER INSTITUTE
Wayne State University

# CONSENT AND AUTHORIZATION

**Affix Label Here**

Name: _____

Date of Birth: _____

PTID: _____

## 1. GENERAL CONSENT TO ADMISSION AND TREATMENT

I, the undersigned, hereby voluntarily request, consent to and authorize all medical and hospital care, including physical examination and screening, diagnostic procedures, drug administration, therapeutic treatments, including drug and alcohol screening, as deemed necessary in the judgment of the attending physician(s), other medical staff members and health care providers of Karmanos Cancer Institute ("KCI"). I am aware that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me with respect to the results of the care and treatment that I have received.

I hereby authorize KCI to retain, preserve and use for scientific or teaching purposes, or to dispose at its discretion or convenience, any specimen or tissues taken from my body during my visit. I authorize KCI to photograph, film and/or record me for the purpose of diagnosis, treatment recommendation and/or documentation and identification while in treatment. I understand that these photographs, films, and/or recordings may be retained as a permanent part of the medical record and may be used for case studies and education. I have been informed and understand that most KCI facilities are teaching institutions and that the medical and surgical procedures performed may require the observation, cooperation and services of multiple health care providers. I authorize such persons to undertake this observation, service and care.

## 2. AFFILIATION WITH THE DETROIT MEDICAL CENTER

KCH is affiliated with The Detroit Medical Center ("The DMC") and under certain circumstances, services may be obtained from, or provided in a Harper University Hospital facility or other facility at The DMC. My signature below indicates my consent to the provision of such services in a DMC facility by The DMC and the doctors, nurses and staff that work at such facilities and to the sharing of my medical records and other health information for treatment purposes.

## 3. CONSENT FOR EXPOSURE TESTING

I understand if an emergency responder, health care professional, or other health facility employee is exposed to my blood or body fluid, that testing including but not limited to HIV, Hepatitis B or Hepatitis C may be performed without my consent, as mandated by MCL 333.20191.

## 4. RELEASE OF INFORMATION FOR INSURANCE

I authorize KCI and its affiliates to release to any third party payer, or its representative, including Medicare, Medicaid, Champus, 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.

## 5. RELEASE OF INFORMATION FOR PUBLIC HEALTH

I authorize KCI to release information contained in my medical record, including information about communicable diseases and/or infections, as defined by Michigan statute and Department of Public Health rules, which include Human Immunodeficiency Virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), venereal disease and tuberculosis, and alcohol and/or drug abuse information protected under the regulations in 42 Code of the Federal Regulations part 2, psychiatric/ psychological records, and social work records, including communications to a social worker, psychiatrist or psychologist.

## 6. ASSIGNMENT OF INSURANCE BENEFITS

I assign and authorize direct payment to KCI of all health benefits and other forms of payment relating to the care provided to me by KCI staff. I assume full financial responsibility for payment of all expenses associated with my care and treatment, including any charges not paid by insurance. These expenses may include, but are not limited to, daily charges for telephone calls, patient-requested private room, and any deductible and coinsurance amounts.

## 7. TELEPHONE CONSUMER PROTECTION ACT

I understand that, from time to time, KCI, its subsidiaries and affiliates (collectively, "KCI") may contact me to (1) discuss any past, current or future services provided by KCI, as permitted under HIPAA; (2) discuss the accounting, billing or other financial information (such as insurance information and service fees) for past, current or future services provided by KCI; and (3) discuss collections of any past due amounts or my eligibility for payment assistance or forgiveness programs.

I consent and agree to KCI and its service providers (a) contacting me at any address (including e-mail) or telephone number (including wireless number or ported landline phone number) that I may provide to KCI; (b) using automated phone dialing systems or prerecorded message calls when contacting me; and (c) sending text messages to my phone number, to carry out the purposes KCI has identified above. I agree to KCI sharing my contact information, including my wireless number and e-mail address, with service providers (including a collection agency) with whom KCI contracts to assist it in pursuing these interests, but I understand that KCI will not share my phone number(s) with third parties for their own purposes without my consent. I understand that standard telephone minute and text charges may apply.

I further understand that I do not have to consent to receive autodialed or prerecorded message calls or texts to receive services from KCI. I may choose to revoke my consent for receiving autodialed or prerecorded message calls or texts by contacting a McLaren

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Customer Representative to inform them of my preferences using the following toll-free number or email address: **(844) 839-3884 or phonecalloptout@mclaren.org.**

## 8. MULTIPLE DATES OF SERVICE

I 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 any KCI facility.

## 9. AUTHORIZATION TO OBTAIN MEDICATION RECORDS FOR CARE COORDINATION

I understand that it is important for my care providers to know what medications I am currently taking, in order for them to prescribe and provide the appropriate treatment for me. I therefore give permission for KCI to obtain and review records from any pharmacy (or pharmacies) which I currently obtain medication(s) from.

## 10. RELEASE OF RESPONSIBILITY: PERSONAL VALUABLES

I understand that KCI is not liable for the loss or damage to any personal property that I choose to keep with me or in my room during my KCI stay, and that I am responsible to make arrangements to keep items of value secured. I have been advised to send all personal valuables home. I also acknowledge that KCI is not responsible for personal items brought in to me during my stay.

_____ (Patient Initials) _____ (Patient Access Rep. Initials)

## 11. NOTICE OF PRIVACY PRACTICES

I have received a copy of KCI's Joint Notice of Privacy Practices, Grievance Procedure, Patient Rights, and Visitation Policy (if applicable):

_____ (Patient Initials) _____ (Patient Access Rep Initials)

Notices Provided, Patient Returned/Refused _____ (Patient Access Rep Initials)

## 12. HEALTH INFORMATION EXCHANGES

I understand that KCI participates in Health Information Exchanges or business operations and to make my health care information available to other providers who may treat me.

## 13. MEDICARE BENEFICIARIES HOSPITAL ADMISSIONS ONLY

I have received a copy of "An Important Message from Medicare"

_____ (Patient Initials) _____ (Patient Access Rep Initials)

## 14. TRICARE BENEFICIARIES HOSPITAL ADMISSIONS ONLY

I have received a copy of "An Important Message from Champus"

_____ (Patient Initials) _____ (Patient Access Rep Initials)

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I certify that I have read this consent form, or that it has been read to me. I understand its contents and agree that by signing this form I am bound by its provisions, whether signed by myself or a representative acting on my behalf.

_____ _____

**PATIENT** Signature (Parent/Guardian, if Minor, or person signing on patient's behalf) Date/Time (**MANDATORY**)

_____ _____

**Relationship** if other than patient Telephone Permission By

_____ _____

Witness Date/Time (**MANDATORY**)

_____ _____

2nd Witness (Permission By Telephone) Date/Time (**MANDATORY**)