McLAREN FLINT

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 therapeutics) 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 488 P.A. 1988, 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 Venereal Disease, Tuberculosis, Hepatitis B, Human Immuno-deficiency 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 insurance 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.

PT.

MR.#/RM.

DR.

4. I hereby assign payment directly to the Hospital/Clinic of the insurance benefits otherwise payable to me but not to exceed the balance due to the hospital's regular charges for this service.

5 I assume full financial responsibility for payment of all services provided to me, including any portion of my bill which is not paid by insurance, workers compensation or social agencies.

6. McLaren Flint will not be liable (responsible) for any money or property of any kind retained by me or kept in my possession while I am at the hospital.

   McLaren Flint advises that all patient valuables (i.e. jewelry, watches, credit cards, electronic devices, and money) be sent home whenever possible. When this is not possible, patients are encouraged to secure valuables in the hospital safe at any time during their admission.

   After 60 days, McLaren Flint will dispose of all unclaimed property left at the medical center. Please call Security at (810) 342-3333, to claim any valuables after discharge.

7. If I possess Medicare [CHAMPUS] coverage, I have received a copy of "An Important Message from Medicare [CHAMPUS]".

8. I possess a Durable Power of Attorney for Health Care and/or Living Will.

   ☐ **Yes** ☐ **No** ☐ **Don't Know**

   If yes, I understand that it is my responsibility to provide the Hospital/Clinic with a current copy of my Durable Power of Attorney for Health Care and/or Living Will.

   For all Inpatients, I acknowledge receipt of advance directive information ("Michigan Notice to Patients" or "Decision" booklet) as required by the Patient Self Determination Act.

9. I have received a copy of the Hospital/Clinic Notice of Privacy Practices. ☐ Received today ☐ Previously received

   _____ **Initials**

This form has been fully explained to me and I am satisfied that I understand its content and significance.

Date Signed: _____

Signature of Patient: _____ Signature of Witness: _____

Signature of Spouse Accepting Financial Responsibility: _____ Signature of Witness: _____

(If patient is a minor or unable to consent, complete the following:)

Patient [is a minor _____ years of age] is unable to consent because _____

Signature of Legal Guardian or Closest Available Relative: _____ Signature of Witness: _____

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17451 REV. 3/15

MR.#/RM. PT.

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DR.