FAMILY HEALTH, PC

Date: _____ / _____ / _____

GENERAL CONSENT TO TREATMENT

Patient's Name _____ MR# _____

1. **CONSENT TO INPATIENT EMERGENCY, CLINIC OR AMBULATORY FACILITY SERVICES TO PROVIDE HEALTH CARE SERVICES AT FAMILY HEALTH**

I request and authorize the type of health care services checked above as my physician, his/her assistants or designees (collectively called "the physicians") advise. These include routine diagnostic, radiology and laboratory procedures, routine therapeutic procedures, routine drugs, and routine medical nursing and hospital care. I understand that in emergencies it may be advisable to expand or deviate from the services listed here in order to preserve my life or health. I consent to these expanded services and procedures. I understand that facility personnel care for me according to the physicians instructions.

2. **CONSENT TO TESTING AND DISPOSAL OF BODILY FLUIDS AND TISSUE**

I understand that the facility may perform non-diagnostic laboratory tests upon specimens of blood, urine, and other bodily fluids/tissues that are withdrawn from me for diagnostic purposes, and the facility may dispose of these specimens as it chooses.

3. **RELEASE OF INFORMATION**

I authorize the facility to release any and all information from my medical record, including:

- information about communicable diseases and serious communicable diseases and infections as defined by statue and Michigan Department of Public Health Rules, which include venereal disease "VD", tuberculosis "TB", human immunodeficiency virus "HIV", Acquired immunodeficiency syndromes "AIDS", and AIDS related complex "ARC".
- substance abuse treatment information protected by 42 Code of Federal Regulation 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 (for example Medicare, Medicaid, Blue Cross/Blue Shield, commercial health insurers, automobile no fault insurers, workers' disability compensation insurers, health maintenance organizations, preferred provider organizations, and manages care plans) which are responsible in whole or in part for paying my health care bill so that the facility may be paid for its services:
  - (b.) any independent auditors or reviewers retained by the facility, or by any third party payor or insurance company (for example Medicare, Medicaid, Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, workers' disability compensation insurers, health maintenance organizations, preferred provider organizations, and managed care plans) so that these reviewers can analyze quality, utilization and/or charges.

*** Facility: The term "Facility" is just a convenient description and does not suggest or create any relationship between the above listed entities.**

4. **NO GUARANTEES OR ASSURANCES**

The facility has made no guarantees or assurances about the results of my hospitalization or health care. I understand that a patient will receive the usual and ordinary care rendered in this community, and that no other contract, written or implied, is made.

PAYMENT PROVISIONS

NOTE: The term "health care benefits" is the following paragraphs means Medicare, Medicaid, maternal and infant health, Blue Cross/Blue Shield, commercial health insurance benefits, automobile no-fault benefits, workers' disability compensation benefits, health maintenance organization, preferred provider organization, or managed care plan coverage, as applicable.

5. I understand that, except in limited circumstances, separate billings will be issued for services of the facility and services of physicians, and that neither's charges are included in the billing of the other.

6. I request payment on my behalf of all health care benefits for services provided by the facility and by physicians for whom the facility is authorized to bill.

7. I assign and transfer to the facility all health care benefits applicable to my care, including those health care benefits listed on the first page of my medical record. I authorize and direct that all such health care benefits be paid directly to the facility.

8. I agree personally to pay for any facility or physician charges not covered by or collected from any applicable health care benefit program, including any deductibles and coinsurance amounts.

I certify that I have read this form that I understand it and consent to it. If the signer is not the patient, the signer certifies that he is the patient's legally authorized representative.

X _____ _____ _____

Signature Date Witness

Note: Please be advised that the Facility may perform an HIV test upon a patient without any special written consent if a health professional, health facility employee, police officer, fire fighter, medical first responder, emergency medical technician, emergency medical technician specialist, or paramedic who sustains in the health facility, while treating the patient before transport to the health facility, or while transporting the patient to the health facility, a percutaneous, mucous membrane, or open wound exposure to the patient's blood or other bodily fluids of the HIV test is performed pursuant to a request under MCL 333.20191(2).