Oakwood®

GENERAL CONSENT FOR TREATMENT

1. **CONSENT TO INPATIENT, EMERGENCY, CLINIC OR AMBULATORY FACILITY SERVICES**
   I request and authorize the type of health care services that my physician(s), or their designees advise. These may include routine diagnostic, radiology and laboratory procedures, routine therapeutic procedures, routine drugs, and routine medical, nursing and hospital care. I agree that in emergencies my physician and/or Facility personnel may expand or deviate from the services listed herein order to preserve my life or health. I understand that Facility personnel will care for me under the physician(s) instructions and as believed necessary for me. I understand the Facility has a role in teaching future health care personnel. To that end, instructors working at the Facility oversee students and trainees. Students and trainees may visit or care for me and may review my health care information as part of their education. I will tell my nurse or doctor if I do not want students or trainees involved in my care.

2. **CONSENT TO TESTING AND DISPOSAL OF BODILY FLUIDS AND TISSUE**
   I understand that the Facility may withdraw from me specimens of blood, urine and other bodily fluids/tissues for diagnostic purposes, and may perform other tests not related to my diagnosis with these specimens, 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 statute and Michigan Department of Public Health Rules, which include venereal disease "VD", tuberculosis "TB", human immunodeficiency syndromes "AIDS" and AIDS related complex "ARC".
   - 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.

   This information may be released 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) that 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 health care facility or physician to which I am referred or transferred for continuity of care;

   c. 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;

   d. my current or potential employer, if the purpose of the medical examination and/or treatment arises from or pertains to my current or prospective employment, e.g., an employment physical or care and treatment arising from a workplace injury;

   e. individuals and organizations that need this information to provide services to Oakwood

This authorization for release of information is effective so long as is necessary to accomplish the purpose for which it is given. This authorization may be revoked at any earlier time unless the Facility has already acted or released information in reliance on it.

4. **PERSONAL VALUABLES**
   I understand that the Facility has a safe where patients may store their money and small valuables. I understand that the Facility is not responsible for loss or damage to any property unless I ask the Facility to put it in the safe.

5. **NO GUARANTEES OR ASSURANCES**
   The Facility has made no guarantees, promises or assurances regarding my hospitalization or healthcare outcomes.

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

(This is a two-sided form. Be sure to read both sides before you sign)

6. **RESTRAINTS**
   I understand that I may need restraints, if medically necessary.

7. **PATIENT RIGHTS**
   I know that a pamphlet on patient's rights and responsibilities will be given to me upon admission or if I ask for one.

PAYMENT PROVISIONS

NOTE: The term "health care benefits" in 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. These payment provisions may be affected by a specific health care benefit program rule.

A. 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 billings of the other.

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

C. 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.

D. 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.

E. I consent to Oakwood Healthcare System contacting various credit bureaus and credit agencies to determine my credit worthiness and obtaining credit reports and other information as necessary to obtain payment for services.

CONSENT OF PATIENT ADVOCATE, LEGAL GUARDIAN, OR NEAREST RELATIVE IF PATIENT IS UNABLE TO SIGN OR IS A MINOR.

Signature of Patient, Patient Advocate,
Guardian or Nearest Relative: _____

Date:_____Time:_____Relationship: _____

Address:_____Phone Number: _____

Signature of Witness:_____Interpreter: _____

NOTICE

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 or the HIV test is performed pursuant to a request under MCL 333.20191 (2).

To be completed if patient does not have picture I.D.
PATIENT INFORMATION

Patient Name:_____ Arrival Date/Time: _____

Chief Complaint: _____

_____

Address: _____

Phone Number:_____ Date of Birth:_____Marital Status: S / M / W /D Sex: M / F

Patient Social Security #:_____Guarantor Name:_____Guarantor SS #:_____

Your Family Doctor: _____

Other Oakwood Doctors involved in your care: _____

(This is a two-sided form. Be sure to read both sides before you sign)