CMU HEALTH
CENTRAL MICHIGAN UNIVERSITY

CONSENT FOR TREATMENT/PAYMENTS/HEALTHCARE OPERATIONS - MINOR

Consent for Services

I request and authorize healthcare services as my physician or other provider, his/her assistants, or designees (collectively called "the Providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostic and laboratory procedures, administration of routine drugs, and other therapeutics, and routine medical and nursing care. 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 with respect to such diagnostic procedures or treatments.

I am aware that CMU Health is a teaching facility, and that resident physicians and medical students may be involved with my care under the supervision of a staff physician. I consent to their involvement and participation in my treatment.

I consent to the photographing, photocopying, or televising of the operation or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific, or educational purposes, provided my identity is not revealed by picture or text.

Payment Authorization

I authorize CMU Health to furnish information to insurance carriers concerning my illness and treatments. I hereby assign to the physician(s) all payment for medical services rendered to my dependents and/or myself. 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' compensation, or any other agency.

Co-Pay Agreement

I understand and authorize a $5.00 processing fee may be charged if my co-pay is not paid at the time services are rendered.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand that CMU Health has the right to change this notice at any time. I may obtain a current copy at any time by contacting CMU Health or by visiting the website at http://med.cmich.edu/patients. I have the right to revoke this consent, in writing, at any time, except to the extent that CMU Health has taken action in reliance on this consent.

I understand that under certain circumstances, CMU Health may use and disclose my health information for teaching or research purposes. This research generally is subject to oversight by an institutional review board to protect patient safety, welfare, and confidentiality. The institutional review board evaluates a proposed research project and its use of health information to balance the benefits of research with the need for the privacy of health information. Even without special approval, I understand and approve the use of my health information for allowing researchers to look at records to help them identify patients who may be included in a research project or for similar purposes. My health information may be used or disclosed for research as "limited or de-identified data sets" which do not include name, address, or other direct identifiers.

I have and understand everything on this form and consent fully and voluntarily to its contents.

Patient Name (print): _____ Date of Birth: _____/_____/_____

Patient Signature: _____ Date: _____

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____ Date: _____

Emergency Contact Person

Name (print): _____ Relationship to Patient: _____ Cell: _____