CMU HEALTH
CENTRAL MICHIGAN UNIVERSITY

CONSENT FOR TREATMENT/PAYMENTS/HEALTHCARE OPERATIONS

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, photo copying, 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 which is not paid by insurance, workers compensation or any other agency.

Co-Pay Agreement

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

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 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.

Acknowledgement of Receipt of the Patient Centered Medical Home (PCMH) Patient-Provider Agreement

I have received a copy of the Patient Centered Medical Home (PCMH) Patient-Provider Agreement, which describes my responsibilities as a patient and those of my CMU Health care team. I understand my responsibilities as outlined in this agreement. I may obtain additional copies of this agreement at any time by contacting CMU Health or by visiting the website http://med.cmich.edu/patients.

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

Patient Signature _____ Date: _____

Patient Name (print): _____

Parent/Guardian Signature: _____ Date _____

Parent/Guardian Name (print): _____

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PATIENT COMMUNICATION FORM - MINOR

The purpose of the form is for you to document 1) if someone else may bring your child to the office for an appointment and 2) your preferences regarding who we can communicate with regarding your child.

SECTION ONE: I would like the following individual(s) to be able to bring my child to the office for routine care:

_____ _____

I understand the above person will NOT be able to consent for vaccinations or procedures unless I also complete the Parental Delegation of Authority Form. By consenting to allow the above individual to bring my child to the office for routine care, I am also authorizing CMU Medical Education Partners to verbally share protected health information during that visit only.

_____ _____

Signature Date

SECTION TWO:

Filling out the rest of this form will allow us to <u>verbally</u> share information with the other individuals you specify or share information with the individuals listed above before or after the appointment they bring the child to. Any request to disclose <u>written</u> information, including but not limited to any information in your child's medical record, will only occur after a written authorization has been completed and signed.
You may revoke this permission at any time by completing a new Patient Communication Form.

COMMUNICATIONS ABOUT MY CHILD

Telephone Contact #: Home: ( ) _____ Cell: ( ) _____
Preferred: Home Cell
Relationship: _____

If unable to reach me:
_____I give practice staff consent to identify themselves and leave messages for me. I understand that the messages may include information on dates or future appointments and/or test results.
_____I do not give practice staff consent to identify themselves and leave messages.

COMMUNICATIONS WITH OTHERS

By signing below, I give permission for my child's care team to **discuss** my child's care (including diagnosis, diagnostic test results, examination information, claim information, and appointment confirmations) with the individuals specified below - if the individuals request information or if my care team believes it is in my best interest. This permission is specific to **my child's <u>current</u> treatment or care at any CMU Health location.**

(1) Name:_____ Relationship/Phone: _____

(2) Name:_____ Relationship/Phone: _____

(3) Name:_____ Relationship/Phone: _____

I have carefully read and understand the information on this form. All of my questions have been answered. I understand that the individuals listed above may continue to receive verbal communications regarding any information they request, until I notify the office, in writing, of my decision to change it.

Minor Name:_____Patient/Legal Representative Signature: _____
Print Name: _____Relationship to Patient: _____ Date: _____