Pediatric & Adolescent Center
15555 Northline Rd
Southgate MI, 48195

Name of Patient_____
Date_____

General Consent to Treatment

Type of treatment: X Clinic X Inpatient X Emergency X Ambulatory

1. CONSENT TO INPATIENT, EMERGENCY, CLINIC, OR AMBULATORY FACILITY SERVICES

I request and authorize the type of health care services checked above as my physician, his/her 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 the 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may perform diagnostic laboratory tests upon specimens of blood, urine and other bodily fluids/tissues that are withdrawn from me for diagnostic purposes, and the facility may dispose of these specimens as it chooses.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 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 virus "HIV", acquired 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:
    a) To any third party payer or insurance company (e.g. 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) 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 payer 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
    c) And any health care facility or physician to which I am referred or transferred for continuity of care.

NO GUARANTEES OR ASSURANCES

The facility has made no guarantees or assurances about the results of my health care. I understand that a patient will receive the usual and ordinary care rendered in the community.

Payment Provisions

NOTE: The term "health care benefits" in the following paragraphs mean Medicare, 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 request payment on my behalf of all health care benefits for services provided by facility and by the physicians for whom the facility is authorized to bill.
6. I assign and transfer to the facility all health care benefits applicable to my care.
7. 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/she is the patient's legally authorized representative.

Date:_____ _____
Signature of patient, or parent (if patient is minor),
Or guardian (if patient is legally incompetent)

Witness:_____ **Address:**_____

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