# Consent
# GENERAL, TREATMENT AND RELEASE OF INFORMATION


Patient Name
DOB
MRN
Physician
CSN

## NOTICE OF NONDISCRIMINATION:

Corewell Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Corewell Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex or any other basis prohibited by law.

## I AGREE:

- To examination and treatment by providers, residents, students, and other healthcare professionals at Corewell Health. This may include in-person, shared medical appointment, telemedicine, videotaping, photographing and audio devices. These tools may be used to treat/diagnose or for procedures to be performed for medical, scientific and/or personal safety.
- As discussed and agreed, the provider may change my and/or my child's care to benefit my life or health.
- If I am here to give birth, the provider and other healthcare professionals may give care to my baby.
- If I am participating in a shared medical appointment, I will attend this appointment with other patients. During these appointments, personal information about me may be shared by my provider to others.
- The provider may obtain specimens of my blood, urine and other bodily fluids/tissues ("specimens"). I authorize the provider to retain and preserve these specimens for scientific and teaching purposes as well as perform other tests not related to my diagnosis on these specimens. The provider may dispose of these specimens as it chooses.

## I UNDERSTAND THAT:

- I will ask questions.
- I am aware the practice of medicine and surgery is not an exact science. No one has made promises or guarantees to me about the results of my treatment, care, or examination at Corewell Health.
- Students and staff may see me and look at my medical record for teaching or research purposes.
- The staff will double-check who I am. They will ask what I am having done. This is to protect me.
- Some providers and staff are not employees of Corewell Health. I know that Corewell Health is not responsible for their care or other actions. I also know I will receive separate bills from them even though they provide services to me at a Corewell Health location. I will work with their offices to answer questions about my insurance.
- Michigan law allows healthcare providers to test my blood for HIV (AIDS virus) or Hepatitis without my consent if someone who has helped in my care is exposed to my blood or body fluids.
- A copy of the Corewell Health Financial Assistance Eligibility Policy is available upon request at all registration areas and on our website at:
  - Corewell Health Southeast Michigan: https://www.beaumont.org/patients-families/billing/financial-assistance
  - Corewell Health Southwest Michigan: https://www.spectrumhealthlakeland.org/patient-visitor-guide/patient/billing/financial-assistance
  - Corewell Health West Michigan: https://www.spectrumhealth.org/billing/financial-assistance
- Corewell Health will not tolerate discrimination against my provider, other healthcare professionals or staff because of race, color, gender, national origin, age, disability, sex or any other basis prohibited by federal, state or local law.
- Should my condition require referral to a specialist, I understand I will be asked my choice of a provider. I will have the opportunity to have Corewell Health contact the provider of my choice or if I do not have a preference, an independent provider from Corewell Health's "on-call" list will be called. I consent to my insurance company billing for professional services given by this provider whether or not this provider participates with my insurance program.

**OVER →**

**Confidentiality of this medical record** shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

**I UNDERSTAND THAT:** ***(CONTINUED)***

- This consent is valid for one (1) year from the date of my signature.

**MY MEDICAL INFORMATION:**

- COREWELL HEALTH MAY RELEASE MY MEDICAL INFORMATION TO:
  - Insurance companies, health plans and administrators for payment of services I or my child receive(s).
  - Government agencies like Medicare and Medicaid or as required by law.
  - My providers and others involved in my care now or in the future.
  - My employer, if the records are related to care or services paid for by my employer, or for other purposes that are allowed under law.
  - Any person or entity responsible to pay all or part of my bill.
- I agree that Corewell Health can take my or my child's picture and save it to my electronic medical record. I understand that Corewell Health will use this picture for identification purposes with the goal of improving patient experience.
- I understand Corewell Health will keep my or my child's medical information according to state law, federal law and policy. I also understand that my medical information may be stored electronically and may be sent to or received from other healthcare providers and/or payers electronically. This includes my diagnosis (what is wrong with me), treatments (what is being done to make me better), and medicine or prescription information. This will also include any details about my mental health, infectious diseases (like HIV), and other problems like drug or alcohol use disorder.
- I authorize my protected health information (PHI) to be sent to my MyChart (patient portal) account. MyChart is a secure internet portal that allows me to see, receive and manage information about my health.
- I understand my protected health information (PHI) may include very personal information (e.g., physical/mental illness, alcohol/drug abuse, sexually transmitted infections (STIs), HIV/AIDS, etc.). If I give someone access to my MyChart portal or request my PHI be shared with a third-party, that third-party will be able to see my PHI (which may include very personal information). By allowing others access to my PHI, I am agreeing that they can see my very personal information including my HIV/AIDS status.
- In some cases, Corewell Health is required by law to report medical information to an agency like the health department. This may include information about HIV, TB and other diseases.
- If I am transferred to another facility, Corewell Health's providers/resident providers may access my medical records to follow up on my care and/or use the information for medical research.

**PRIVACY NOTICE:**

- I have rights and responsibilities when I or my child receive(s) services. I have had the opportunity to receive a copy of the Notice of Privacy Practices and have had an opportunity to ask questions about the information in the Notice.

**VALUABLES:**

- Corewell Health would like its patients to leave valuables at home or with family members. I agree Corewell Health is not responsible for safeguarding my property.

**PATIENT RIGHTS AND GRIEVANCES:**

- I understand that I may submit a concern or complaint without fear of reprisal or retaliation. Efforts will be made to resolve my concern promptly or within an appropriate timeframe. If I have questions about my rights as a patient, I may ask questions. The phone number for each region is:
  Corewell Health Southeast Michigan - 947.522.1472
  Corewell Health Southwest Michigan - 269.932.9367
  Corewell Health West Michigan - 855.613.2262
  I may also express my concern to the Patient and Family Experience Representative at the location where I receive care.

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***CONTINUED ON PAGE 3 ➔***

Patient Name
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**CONSENT TO CONTACT:**

- I have given residential and/or cellular telephone numbers and an email address to Corewell Health. I consent to receive autodialed and/or pre-recorded telephone calls, text messages and/or emails from Corewell Health and/or its agents/third parties. These communications may include billing. I am responsible for any communication charges from my phone provider(s). This authorization is voluntary. I can still be treated even if I do not give "consent to contact".
- Text messages from Corewell Health might include the date and time of my appointment, my provider's name, the name and address of the location where my appointment is scheduled, and what I need to know to prepare for my appointment, amounts owed, or limited health information.
- I authorize Corewell Health to send unencrypted text messages to the cell phone I have on file in my Corewell Health medical record. I understand that:
    - Text messages are unencrypted. Health Information sent in an unencrypted text message may be intercepted and seen by others. There are other risks with unencrypted text message including misdirected texts, messages forwarded to others, and messages that are stored on servers that have no security. By choosing to receive your Health Information by unencrypted text, you are acknowledging and accepting these risks.
    - This Authorization is valid until I revoke or withdraw my permission to receive text messages.
    - I may revoke or withdraw this Authorization, except to the extent that action has been taken prior to the receipt of the revocation or withdrawal, at my provider's office or by calling:
      Corewell Health Southeast Michigan - 248.597.2727
      Corewell Health Southwest Michigan - 269.982.9300
      Corewell Health West Michigan - 877.308.5083

**AUTHORIZATION TO RECEIVE PAYMENT AND BILLING:**

- Corewell Health is authorized to seek payment from any third party and from me. I authorize Corewell Health to act on my behalf to collect benefits from any third party and endorse checks payable to me and/or Corewell Health.
- I authorize any insurance company, responsible for payment of my medical care and treatment, to pay Corewell Health for the services given. I understand that I am responsible for any charges not covered by insurance.
- I request payment due to me of authorized Medicare benefits be paid (on my behalf) to Corewell Health for any services provided to me by Corewell Health or in its facilities.
- I agree that if my account is not paid when due, Corewell Health may retain a lawyer and/or collection agency for collection. I will be responsible to reimburse Corewell Health for all costs, charges and fees associated with the collection of the amount due. This includes, but not limited to, reasonable interest, legal cost in the event suit is filed and reasonable lawyer fees and/or reasonable collection agency fees including those based on a percentage of the debt.
- I agree the information given by me for payment is correct. I know pre-certification or pre-authorization for services is my responsibility.
- If I do not want Corewell Health to bill my insurance, I must notify them at the time of service.
- Corewell Health may obtain a credit report to determine if I am eligible for certain uninsured (self-pay) discounts or financial assistance programs. This will not impact my credit score.
- Divorced Parents of Minor Patients:
    - Corewell Health's medical record system allows for one parent/legal guardian to be assigned as a guarantor (the individual responsible for paying the bill). Parents are responsible to communicate (between themselves) with each other about payment of any charges not covered by insurance.

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## AUTHORIZATION TO RECEIVE PAYMENT AND BILLING: *(CONTINUED)*

- Outpatient Medicare Patients:
  - I know that Medicare rules make me responsible for self-administered medicines furnished to me while an outpatient. Self-administered medicines are typically medicines that I take without professional help but may be administered by Provider personnel in the outpatient setting such as the Emergency Department outpatient department or in observation. Medicare requires hospitals to bill Medicare patients or other third-party payers for these medicines. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these medicines in accordance with Medicare Drug plan enrollment materials.

## ASSIGNMENT:

- I assign Corewell Health:
  - All benefits, claims, and any and all other rights, including the right to bill and talk to any third party for the purpose of seeking payment, regarding my charges at Corewell Health.
  - The right to file suit or intervene in any lawsuit or proceeding which involves my charges at Corewell Health.
  - The right to take any other action to seek payment of my charges at Corewell Health.
- This assignment includes, but is not limited to, the right to appeal the denial of payment of my Corewell Health charges from any payer, including any employer-sponsored benefit plan, insurance policy or insurance coverage provided by law or contract.
- I also assign to Corewell Health, and agree that I waive, any and all rights to settle, release or retain payment of my Corewell Health charges, or take any other action which would in any way compromise payment or reimbursement of my Corewell Health charges.
- I also appoint Corewell health as my authorized representative for the purpose of pursuing payment for my Corewell Health charges. I authorize Corewell Health to act on my behalf to pursue any benefit claim, including one under Employee Retirement Income Security Act of 1974, and to appeal an adverse benefit determination. I agree to assist Corewell Health in the pursuit of all insurance benefits and agree to pay all co-insurance, co-payments and deductibles required by any insurance plan.
- I authorize and direct Corewell Health to apply the proceeds of any recovery to my Corewell Health charges.

## TRANSLATION:

- I understand I can access this document in other languages upon request.

## PATIENT SIGNATURE(S):

I have read this form and I understand it. All my questions have been answered.

**TIME** ____________ ☐AM ☐PM **DATE** ____________ Patient signature ______________________________

- Patient is under 18 years of age or otherwise unable to consent because ______________________

**TIME** ____________ ☐AM ☐PM **DATE** ____________ Parent/Legal Guardian signature ____________________

Printed name ______________________________

**STAFF SIGNATURE(S):**

**TIME** ____________ ☐AM ☐PM **DATE** ____________ Witness ______________________________

SECOND WITNESS NEEDED FOR VERBAL CONSENT:

**TIME** ____________ ☐AM ☐PM **DATE** ____________ Witness ______________________________

**INTERPRETING SERVICES:**

I certify that I have interpreted, to the best of my ability, into and from the participant's stated primary language, ______________________, all oral presentations made by all of those present during the informed consent discussion.

**TIME** ____________ ☐AM ☐PM **DATE** ____________ Interpreter signature ______________________________

Interpreter name (print) ______________________________

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