



# Consent GENERAL, TREATMENT AND RELEASE OF INFORMATION (2 SIDED) Page 1 of 4

Patient printed name \_\_\_\_\_

Medical record number \_\_\_\_\_ Account number \_\_\_\_\_ Date \_\_\_\_\_

## NOTICE OF NONDISCRIMINATION:

Spectrum Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Spectrum Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. See pages 3 and 4 for the complete notice of nondiscrimination as well as availability of language assistance.

## I AGREE:

- To the care and treatment the doctor and other healthcare professionals have ordered. The doctor may have help from other healthcare professionals.
- That the doctor may change my care to benefit my life or health.
- If I am here to give birth, the doctor and other healthcare professionals may give care to my baby.

## I UNDERSTAND THAT:

- I will ask questions.
- No one has made promises about the results of my treatment or care.
- 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 doctors and staff are not employees of Spectrum Health. I know that Spectrum 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 Spectrum 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 Spectrum Health Financial Assistance Eligibility Policy is available upon request at all Registration Areas and on our website at [www.spectrumhealth.org](http://www.spectrumhealth.org).
- Spectrum Health will not tolerate discrimination against my doctor, 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.

## MY MEDICAL INFORMATION

- SPECTRUM HEALTH MAY RELEASE MY MEDICAL INFORMATION TO:
  - Insurance companies, health plans and administrators for payment of services I receive.
  - Government agencies like Medicare and Medicaid or as required by law.
  - My doctors 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 Spectrum Health can take my picture and save it to my electronic medical record. I understand that Spectrum Health will use this picture for identification purposes with the goal of improving my patient experience as I move throughout the Spectrum Health system.
- I understand Spectrum Health will keep my 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 we are doing to make me better), and medicine or prescription information about my mental health, infectious diseases like HIV, and other problems like drug or alcohol use may be included.
- In some cases, Spectrum 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.

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.



**OVER →**

DO NOT MARK BELOW THIS LINE      BARCODE ZONE      DO NOT MARK BELOW THIS LINE

250051 (5/17) - Page 1 of 4 © Spectrum Health  
 (Spanish X04879) (Vietnamese X04878)  
 (Bosnian X11959) (Arabic X18622)  
 (Burmese X18623) (Korean X18624)  
 (Swahili X18625) (Kinyarwanda X18626)  
 (Somali X18627) (Nepali X18628) (Chinese X18629)



# GENERAL, TREATMENT AND RELEASE OF INFORMATION (2 SIDED) (CONTINUED)

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## PRIVACY NOTICE

- I have rights and responsibilities when I receive services. Spectrum Health has given me its Notice of Privacy Practices, and I have had an opportunity to ask questions about the information in the Notice.

## VALUABLES

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

## CONSENT TO CALL

- I have provided residential and/or cellular telephone numbers and an email address to Spectrum Health. I consent to receive autodialed and/or pre-recorded telephone calls, text messages and/or emails from Spectrum Health and/or its agents/third parties at any of these phone numbers for communication including billing purposes. I understand that my consent to call is not a condition of my treatment.

## AUTHORIZATION TO RECEIVE PAYMENT

- Spectrum Health is authorized to act on my behalf in the collection of benefits from any third party and in the endorsement of checks payable to me and/or Spectrum Health. I understand that Spectrum Health is authorized to seek payment from any third party and from me.

## ASSIGNMENT

- I assign Spectrum 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.
  - The right to file suit or intervene in any lawsuit or proceeding which involves my charges at Spectrum Health.
  - The right to take any other action seeking payment of my Spectrum Health charges.
- This assignment includes, but is not limited to, the right to appeal the denial of payment of my Spectrum Health charges from any payer, including any employer-sponsored benefit plan, insurance policy or insurance coverage provided by law or contract. I authorize Spectrum Health to act on my behalf to pursue an ERISA benefit claim or to appeal an adverse benefit determination. I agree to assist Spectrum 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 also assign to Spectrum Health, and agree that I waive, any and all rights to settle, release or retain payment of my Spectrum Health charges, or take any other action which would in any way compromise payment or reimbursement of my Spectrum Health charges.

## BILLING

- I authorize any insurance company, responsible for payment of my medical care and treatment, to pay Spectrum Health for the services given. I understand that I am responsible for any charges not covered by insurance.
- I agree that if my account is not paid when due, and the hospital should retain a lawyer and/or collection agency for collection, I will be responsible to reimburse the hospital for all costs, charges and fees associated with the collection of the amount due including, but not limited to, reasonable interest, legal costs 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.

## 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/Patient Advocate/Next of Kin signature \_\_\_\_\_

Printed name \_\_\_\_\_

## STAFF SIGNATURE(S)

TIME \_\_\_\_\_  AM  PM DATE \_\_\_\_\_ Witness \_\_\_\_\_

## SECOND WITNESS NEEDED FOR VERBAL CONSENT

TIME \_\_\_\_\_  AM  PM DATE \_\_\_\_\_ Witness \_\_\_\_\_

## INTERPRETATION 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) \_\_\_\_\_

Patient printed name \_\_\_\_\_

Medical record number \_\_\_\_\_ Account number \_\_\_\_\_ Date \_\_\_\_\_

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**SPECTRUM HEALTH:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Spectrum Health Language Services at 616.267.9701, 1.844.359.1607 (TTY:711).

If you believe that Spectrum Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex:

- You can file a grievance with:
  - Director, Patient Experience
  - 100 Michigan Street NE, MC 006
  - Grand Rapids, MI 49503
  - 616-391-2624 or toll free: 1-855-613-2262
  - patient.relations@spectrumhealth.orgYou can file a grievance in person, by mail or by email. If you need help filing a grievance, the Director of Patient Experience is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:
  - U.S. Department of Health and Human Services
  - 200 Independence Avenue SW, Room 509F, HHH Building
  - Washington, DC 20201
  - 1-800-368-1019 or 800-537-7697 (TDD)Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**CONTACT US:**

**Español (Spanish)**

ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-359-1607 (TTY: 711).

**العربية (Arabic)**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-359-1607 (رقم هاتف الصم والبكم: 711).

**中文 (Chinese): 國語/普通話 (Mandarin), 粵語 (Cantonese)**

請注意：如果您講中文，你可以獲得免費的語言輔助服務。請撥打 1-844-359-1607 (TTY 手語翻譯：711)。

**Tiếng Việt (Vietnamese)**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-359-1607 (TTY: 711).

**Ako govornite srpsko (Serbian, Croatian or Bosnian)**

OBAVJEŠTENJE: Ako govornite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-844-359-1607 (TTY: 711). (TTY-Telefon za osobe sa oštećenim govorom ili sluhom: 711).

# GENERAL, TREATMENT AND RELEASE OF INFORMATION (2 SIDED) (CONTINUED)

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## NOTICE OF NONDISCRIMINATION: (CONTINUED)

CONTACT US: (CONTINUED)

### አማርኛ (Amharic)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-844-359-1607. (መስማት ለተሳናቸው: (TTY: 711).

### नेपाली (Nepali)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-844-359-1607 (टिडिवाइ: (TTY: 711).

### Thuɔŋjaŋ (Nilotic – Dinka)

PIŊ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ̄ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-844-359-1607 (TTY: 711).

### Kiswahili (Swahili)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-844-359-1607 (TTY: 711).

### فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1.844-359-1607 تماس بگیرید.

### Français (French)

ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1.844-359-1607 (TTY: 711).

### (Burmese)

အသိပေးခြင်း

သင်ပြောသော ဘာသာစကားကို အခမဲ့ ဘာသာပြန် ရှိပါသည်။ ဖုန်းခေါ်ရန်

### فارسی دری (Dari)

توجه اگر به زبان دری صحبت می کنید، خدمات کمک زبانی بصورت رایگان برای شما در دسترس است. تماس ب 1-844-359-1607 (TTY: 711).

### Kreyòl Ayisyen (Haitian Creole)

ATANSYON: Si ou pale Kreyòl Ayisyen, gen èd nan lang ki disponib gratis pou ou. Rele nimewo 1-844-359-1607 (TTY: 711).

### Ikinyarwanda (Kinyarwanda)

ICYITONDERWA: Niba uvuga ikinyarwanda, serivisi z’ubufasha ku byerekeye ururimi, urazihabwa, ku buntu. Hamagara 1-844-359-1607 (ABAFITE UBUMUGA BW’AMATWI BIFASHISHA ICYUMA CYANDIKA -TTY: 711).

### Soomaali (Somali)

DIGTOONI: Haddii aad hadasho Soomaali, adeegyada caawimada luqadda, oo bilaasha, ayaad heli kartaa. Wac 1.844-359-1607 (TTY: 711).

### اللہجة السودانية (Sudanese)

انتباه: إذا كنت تتحدث اللهجة السودانية، خدمات المساعدة بلغتك متاحة مجاناً. اتصل على الأرقام 1-844-359-1607 (رقم الصم والبكم: 711).

### தமிழ் (Tamil)

கவனம்: நீங்கள் தமிழ் பேசினால், உங்களுக்கு இலவசமான மொழி உதவிச் சேவைகள் கிடைக்கின்றன. இந்த எண்ணை அழைக்கவும்: 1-844-359-1607 (TTY: 711).

### ትግርኛ (Tigrinya)

ትግርኛ: ትግርኛ እንደታወቀ ገና ገና ትግርኛ ለማድረግ ገና ገና ከቻርበልክ እየሞ። ደወል 1.844-359-1607 (TTY: 711)።

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