HENRY FORD HEALTH®

General Consent
(Use for all Inpatient and Outpatient Services)

Place patient label here or fill out information below:

Patient Name: _____

Date of Birth: _____

MRN: _____

Read all of this form before signing.

Consent For Inpatient Or Outpatient Treatment. I agree to receive health care services for myself or my child, including medical care, tests, procedures, drugs and other therapies that may be ordered. I agree to give samples of my blood, urine, other body fluids or tissue for testing when needed. I understand that:

- My healthcare providers will explain my treatment plan and procedures to me so that I can make decisions about my care
- I can ask questions at any time
- I can refuse to receive care at any time
- Supervised residents and students may be involved in my care
- I might need to sign a different consent form for some kinds of procedures or treatments
- Health care is not an exact science, and the treatment I receive might not achieve the result I expect
- My healthcare providers have made no guarantees or promises to me about the results of my treatments or procedures

Infant Care. If I have a baby while I am in the hospital, I agree to my baby having all medical care, treatment, tests, procedures, drugs and other therapies that are ordered.

Consent to Pictures or Video. I agree that pictures or videos may be taken during treatment, procedures or for security purposes, which can be used or disclosed for treatment or healthcare operations including education and performance improvement.

HIV Testing. I understand that if a staff member or first responder is exposed to my blood or body fluids, an HIV test may be performed without any additional consent from me. I will receive information before the test is done. I understand that test results will be shared with the person who was exposed and the people who provided care to me.

Personal Valuables. I agree that the hospital, doctor's office or clinic is not responsible for the loss or damage of any personal property that I decide to keep with me while receiving healthcare services. I agree to release the hospital, its staff and healthcare providers from all responsibility if my personal property is lost or damaged.

Drug-Free Facility. I acknowledge that this is a drug-free facility which means I may not use illegal drugs, alcohol or tobacco products (including vaping devices) while I am on the property of the hospital, doctor's office, or clinic. If I have been admitted to the hospital, I understand that I will be offered medications and support to help me with withdrawal symptoms. I agree that if I decide to use illegal drugs, alcohol, or tobacco products (including vaping devices), the hospital may assume that I am voluntarily discharging myself against medical advice.

Consent to Use & Release Health Information. I consent to the hospital, physicians and other healthcare providers using or disclosing (sharing) my protected health information for treatment, payment or healthcare operations, which includes sending my immunization records electronically to the Michigan Immunization Registry (MICR), and as described in Henry Ford Health System's Notice of Privacy Practices.

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Release of Medical Information. I give my permission to the hospital, doctor's office or clinic to release my protected health information to: (a) any of my other healthcare providers for continuing care, and (b)my insurance company and any federal, state or other agency responsible for paying for all or a part of my care (for example, agencies like Medicare, Medicaid, Blue Cross/ Blue Shield), including the agencies that they use to review my care in order to receive payment, reimbursement, or plan for my treatment, procedures or discharge. I understand that discharge planning may include releasing my protected health information to another hospital, extended care facility or home health agency that may be involved in my care after discharge. This includes the release of (if any): alcohol and drug abuse treatment records protected under the regulations in 42 Code of Federal Regulations, Part 2, records of mental health services I may have received, HIV related records, and social service records. I understand that my permission to release drug and alcohol abuse treatment records can be revoked (taken back) at any time, except for those records that have already been released.

Payment Authorization. I give permission to my insurance company and any federal, state or other agency responsible for paying for all or a part of the cost of the care I received to pay the hospital, doctor's office or clinic, directly for the care that I received, instead of paying me directly. I understand I am responsible for paying the hospital, doctor's office or clinic for any remaining co- pays, deductibles or other charges related to the care and treatment I received, unless it is not allowed under federal or state laws.

If my health insurance plan does not accept assignments of benefits or right to payment for services, the following shall apply:

- In the event that any portion of the Henry Ford Health charges are denied by my insurance company, any employer-sponsored benefit plan, or any state or federal agency responsible to pay all or part of the cost of the care I got at Henry Ford Health, I authorize Henry Ford Health to act as my representative, to enforce my rights under my insurance policy, benefit plan, state or government agency plan in order to secure payment of my charges at Henry Ford Health.
- Henry Ford Health, as my representative, shall have the right to talk to any third party for the purpose of seeking payment, the right to seek an appeal of any benefit or payment denial, the right to file a lawsuit or any other proceeding which involves my charges at Henry Ford Health, and the right to take any other action, on my behalf and as my representative, seeking payment of my Henry Ford Health charges.

I have read all of this form or someone has read it to me. I understand and agree with what it says.

_____ _____ _____ am/pm

Patient, Parent, Patient Advocate, Guardian's Signature | Date | Time

_____ _____

Print Name | State Relationship if not the patient

☐ _____/_____

Check Box and Print Name & Company if Interpreter Used