

# **CONSENT AND AUTHORIZATION**

## **1. GENERAL CONSENT TO ADMISSION AND TREATMENT**

I, the undersigned, hereby voluntarily request, consent to and authorize all medical and hospital care, including physical examination and screening, diagnostic procedures, drug administration, therapeutic treatments, including drug and alcohol screening, as deemed necessary in the judgment of the attending physician(s), other medical staff members and health care providers of McLaren Health Care subsidiaries ("McLaren"). I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me with respect to the results of the care and treatment that I have received.

I hereby authorize McLaren to retain, preserve and use for scientific or teaching purposes, or to dispose at its discretion or convenience, any specimen or tissues taken from my body during my visit. I authorize McLaren to photograph, film and/or record me for the purpose of diagnosis, treatment recommendation and/or documentation and identification while in treatment. I understand that all documentation in the medical record including photographs, films, and/or recordings may be retained as a permanent part of the medical record and may be used for case studies and education. I have been informed and understand that most McLaren facilities are teaching institutions and that the medical and surgical procedures performed may require the observation, cooperation and services of multiple health care providers. I authorize such persons to undertake this observation, service and care. I understand that if I do not feel comfortable with a particular provider or student, I have the right to decline to receive care from that provider or student and seek care from another provider; however, in a life-threatening emergency, my choice of provider may be limited depending on the availability of health care providers.

## **2. CONSENT FOR EXPOSURE TESTING**

I understand if an emergency responder, health care professional, or other health facility employee is exposed to my blood or body fluid, that testing including but not limited to HIV, Hepatitis B or Hepatitis C may be performed without my consent, as mandated by MCL 333.20191.

## **3. RELEASE OF INFORMATION FOR INSURANCE**

I authorize McLaren and its affiliates to release to any third party payer, or its representative, including Medicare, Medicaid, Champus, Blue Cross/Blue Shield, commercial health insurers, automobile no fault insurers, workers' disability compensation insurers, employers, health maintenance organizations, preferred provider organizations and managed care plans, which may be responsible for payment in my case, or as required by law, such information from my medical record as is necessary in order to receive reimbursement for any billings rendered relating to my treatment, including alcohol and drug abuse records protected under the regulations in 42 CFR, Part 2, if any, and social services records, if any, and psychological service records including communications by me to a social worker or psychologist. I appoint McLaren and its affiliates to act as my representative to appeal any payment denials for services McLaren has provided. This includes requesting, presenting or eliciting evidence, obtaining appeals information, and receiving any notice in connection with any claim, appeal, grievance or request on my behalf.



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### 4. RELEASE OF INFORMATION FOR PUBLIC HEALTH

I acknowledge McLaren is required to release information contained in my medical record, including information about communicable diseases and/or infections, as defined by Michigan statute and Department of Public Health or Ohio Department of Health rules, which include Human Immunodeficiency Virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), venereal disease and tuberculosis, and alcohol and/or drug abuse information protected under the regulations in 42 Code of the Federal Regulations part 2, psychiatric/ psychological records, and social work records, including communications to a social worker, psychiatrist or psychologist.

### 5. ASSIGNMENT OF INSURANCE BENEFITS

I assign and authorize direct payment to McLaren of all health benefits and other forms of payment relating to the care provided to me by McLaren staff. I assume full financial responsibility for payment of all expenses associated with my care and treatment, including any charges not paid by insurance. These expenses may include, but are not limited to, daily charges for telephone calls, patient-requested private room, and any deductible and coinsurance amounts.

### 6. TELEPHONE CONSUMER PROTECTION ACT

I understand that, from time to time, McLaren, its subsidiaries and affiliates (collectively, "McLaren") may contact me to (1) discuss any past, current or future services provided by McLaren, as permitted under HIPAA; (2) discuss the accounting, billing or other financial information (such as insurance information and service fees) for past, current or future services provided by McLaren; and (3) discuss collections of any past due amounts or my eligibility for payment assistance or forgiveness programs.

I consent and agree to McLaren and its service providers (a) contacting me at any address (including e-mail) or telephone number (including wireless number or ported landline phone number) that I may provide to McLaren; (b) using automated phone dialing systems or prerecorded message calls when contacting me; and (c) sending text messages to my phone number, to carry out the purposes McLaren has identified above. I agree to McLaren sharing my contact information, including my wireless number and e-mail address, with service providers (including a collection agency) with whom McLaren contracts to assist it in pursuing these interests, but I understand that McLaren will not share my phone number(s) with third parties for their own purposes without my consent. I understand that standard telephone minute and text charges may apply.

I further understand that I do not have to consent to receive autodialed or prerecorded message calls or texts to receive services from McLaren. I may choose to revoke my consent for receiving autodialed or prerecorded message calls or texts by contacting a McLaren Customer Representative to inform them of my preferences using the following toll-free number or email address: (844) 839-3884 or [phonecalloptout@mcclaren.org](mailto:phonecalloptout@mcclaren.org).

### 7. MULTIPLE DATES OF SERVICE

I understand that my treatment may require more than one date of service, therefore this consent shall carry full force and effect from the date of signature until I am discharged from treatment; I

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understand that treatment may be rendered at any McLaren facility.

### 8. AUTHORIZATION TO OBTAIN MEDICATION RECORDS FOR CARE COORDINATION

I understand that it is important for my care providers to know what medications I am currently taking, for them to prescribe and provide the appropriate treatment for me. I therefore give permission for McLaren/Karmanos to obtain and review records from any pharmacy (or pharmacies) which I currently obtain medication(s) from.

### 9. INTERPRETER SERVICES

For patient safety, timely/effective communication and language availability for patients with limited English proficiency and/or those requiring American Sign Language interpretation, McLaren provides free on-demand technology interpreter services, including Video Remote Interpreting (VRI) and Over the Phone Interpreting (OTP). If there are technical difficulties or patient needs require an alternative approach, a member of management may assist in coordinating in-person interpreter services. By signing this form, I consent to the use of VRI and OTP.

### 10. FOR PREGNANT OR NEW POST-PARTUM PATIENTS

I understand that McLaren is required to perform screening tests for HIV, Hepatitis B and sexually transmitted infection whenever a pregnant patient initially presents for prenatal treatment or delivery (or immediately after delivery if an infant was delivered outside of the hospital) and test results are not readily available to the care provider. By signing this form, I consent to having these tests performed.

### 11. RELEASE OF RESPONSIBILITY: PERSONAL VALUABLES

I understand that McLaren is not liable for the loss or damage to any personal property that I choose to keep with me or in my room during my McLaren stay, and that I am responsible to make arrangements to keep items of value secured. I have been advised to send all personal valuables home. I also acknowledge that McLaren/Karmanos is not responsible for personal items brought with me during my stay.

### 12. CONSENT TO NOTIFICATION OF A FAMILY MEMBER – HOSPITAL ADMISSIONS ONLY

I authorize McLaren to notify my family member.

☐ (Yes); Family Member Name: \_\_\_\_\_ Phone: \_\_\_\_\_

☐ (No)

### 13. CONSENT TO NOTIFICATION OF YOUR PRIMARY CARE PHYSICIAN – HOSPITAL ADMISSIONS ONLY

Only when I am admitted to a hospital, by providing the name of my Primary Care Provider (PCP), I am consenting for McLaren to notify that provider of my hospital admission.

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### 14. NOTICE OF PRIVACY PRACTICES

I have received a copy of McLaren's Joint Notice of Privacy Practices, Grievance Procedure, Patient Rights, and Visitation Policy (if applicable):

Patient Returned/Refused \_\_\_\_\_ (Patient Access Rep Initials)

### 15. HEALTH INFORMATION EXCHANGES

I understand that McLaren participates in Health Information Exchanges for business operations and to make my health care information available to other providers who may treat me.

### 16. Ohio Only

A Pharmacist may be utilized in the management of your care and you or an individual authorized to act on your behalf can withdraw from the pharmacist consult agreement.

I certify that I have read this consent form, or that it has been read to me. I understand its contents and agree that by signing this form I am bound by its provisions, whether signed by myself or a representative acting on my behalf.

\_\_\_\_\_  
**PATIENT** Signature (Parent/Guardian, if Minor, or  
person signing on patient's behalf)

\_\_\_\_\_  
Date/Time (**MANDATORY**)

\_\_\_\_\_  
**Relationship** if other than patient

\_\_\_\_\_  
Telephone Permission By

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date/Time (**MANDATORY**)

\_\_\_\_\_  
2nd Witness (Permission by Telephone)

\_\_\_\_\_  
Date/Time (**MANDATORY**)

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