Physician Office Consent to Treatment

I. CONSENT FOR MEDICAL CARE, TESTING, AND TREATMENT:

A. I voluntarily consent to treatment which may include a complete medical history, physical examination, performance of diagnostic procedures, lab tests, x-rays, and other medical procedures as deemed necessary and appropriate by the physician, physician assistant, nurse practitioner and/or associates, including residents, students, nurses, technicians, and assistants (each a "Provider") participating in my care on behalf of [Trinity Health IHA Medical Group or Trinity Health Medical Group] ("Facility"). I understand that, absent an emergency or extraordinary circumstance, I have the right to discuss all procedures or treatments with any Provider participating in my care, and to refuse any proposed procedure or course of treatment.

B. I am aware that the practice of medicine and surgery is not an exact science, and that results and outcomes of treatment are different for each patient. I acknowledge that no guarantees or promises have been made to me regarding my health or the results or outcomes of any procedure, test, or treatment that I authorize my Provider to perform.

C. I authorize Facility to dispose of any specimen or tissue remaining after completion of a clinical procedure or treatment.

D. I understand that in the rare event that a Provider is exposed to my blood and/or body fluids, Facility may perform laboratory studies on my blood to detect the presence of any serious communicable diseases, such as hepatitis, HIV or AIDS. I understand Michigan law permits this testing without my consent and, should such testing occur, I will not be charged.

II. NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT AND RELEASE OF HEALTH RECORD INFORMATION:

A. I acknowledge that I was offered and/or provided Facility's Notice of Privacy Practices, and that I may obtain an additional copy of the Notice at any time. This Notice describes how Facility uses and discloses protected personally identifiable information, including billing and medical information, in accordance with the protections of the law.

B. I understand that the Facility may release my personal, billing, and medical information to other institutions, facilities, providers, payers, insurance companies or review agencies for use in connection with my current or future care, health care operations, including quality improvement and care coordination, or as required for Facility or Providers to receive payment for care. I understand and agree that this may include the following: (i) alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2; (ii) information related to HIV infection or AIDS; (iii) psychological records, social services records, and confidential communications made to a psychologist, social worker, or other provider.

C. I understand and acknowledge that my information can be shared by Facility with other past, future, and current providers, caregivers, and facilities to coordinate my health care, for payment and for administrative purposes, including quality and care management, or as otherwise permitted or required by law. This information may include dates and services provided, location where treatment was received, treatment information, medications, diagnoses, names of physicians and other health care providers, including mental health professionals, and information related to diagnosis, care, or treatment of my mental or emotional condition.

D. I acknowledge that my health record information may be released to my employer if this is a work-related exam or an injury for which a workers compensation claim has been filed.

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III. AUTHORIZATION FOR PAYMENT/ FINANCIAL RESPONSIBILITY

A. I assign and authorize payment directly to Facility for all services rendered. I understand that I am financially responsible for services that may not be covered under my health insurance policy or third-party payments except where contrary to law. I understand that it is my responsibility to pay for all charges not covered by my insurance company (including deductibles and co-payments). Facility offers a financial assistance program for qualified patients who cannot pay the full portion of their bill. [Add contact #].

B. Receiving services at a designated provider-based office is the same as receiving services from one of Facility's affiliated hospitals. I understand that separate billing may be issued for both the services of the

Facility and the services of the healthcare professionals, and that neither's charges are included in the billings of the other.

IV. ADDITIONAL ACKNOWLEDGMENTS

A. **Communication Methods**: I agree that Facility and its business associates may contact me by any phone number provided by me or associated with my health record. Facility may contact me by sending text messages or emails, using the contact information I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device. I understand that I can choose not to participate in some or all these methods by completing an opt out form.

B. **No Tolerance for Violence. I acknowledge that Trinity Health has a "Zero Tolerance for Violence" policy**. *This applies to all patients, colleagues, volunteers, and visitors. I understand that incidents may result in removal from the facility, dismissal from the practice and potential criminal prosecution.*

C. **Chaperone:** I understand that Facility allows for a chaperone during my visit, and I will let my Provider, or the Facility staff know if I would like a chaperone present.

D. **Missed Appointment Policy:** I acknowledge that Facility has a missed appointment policy and that I may request the policy for review. I agree to notify the office as soon as possible if unable to keep a scheduled appointment time.

E. **Photography or Recording:** I consent to photography or videotaping of my care and the procedures performed, including appropriate portions of my body, as the Facility or Provider determines will benefit my care, and for quality improvement, scientific research, or educational purposes, provided my identity is not revealed by the pictures or by the descriptive text accompanying them. If the photographs, or recordings identify me in any way and are used for my care, those recordings will be retained by as part of my health record

F. **Personal Valuables**: I understand that Facility does not accept responsibility for any lost, stolen, or damaged personal items while I am at the office.

G. **Telemedicine Services**: I understand that I may receive care through telemedicine services. Telemedicine is the use of medical and personal information exchanged between clinician and patient via electronic communications and technology to improve a patient's health status.

THE PURPOSE OF THIS FORM WAS EXPLAINED TO ME AND I HAD THE OPPORTUNITY TO ASK QUESTIONS

Print Patient Full Name		Patient Date of Birth
Patient Signature	Date	Time

If patient is a minor or adult under guardianship, parent or legal guardian must sign

Signature of Parent or Legal Guardian	Date	Time

Print Name and Relationship to Patient. Describe authority to sign on behalf of patient