CEDAR CREEK HOSPITAL of Michigan

Patient Label

CONSENT FOR TREATMENT & CONDITIONS OF ADMISSION

By initialing each item, the patient/legal guardian acknowledges their understanding of the item as explained by a CCH staff. If consent is withheld for any reason, the word "REFUSED" must be written in the space.

1. **CONSENT FOR TREATMENT** **PATIENT/GUARDIAN INITIALS:** ___________
   The undersigned authorizes CCH, its staff, and attending physicians to render to the patient all customary care, therapy, treatment, tests and procedures considered advisable, including emergency treatment and transportation to another facility if necessary. Further consent is given for any diagnostic procedures, medical treatment, protective confinement, x-rays, recreational activities / therapy and other treatment ordered by the attending physicians including but not limited to services provided by other Healthcare Professionals.
2. **CONSENT FOR EMERGENCY TREATMENT** **PATIENT/GUARDIAN INITIALS:** ___________
   In case of emergency, I give my consent to be transported to, if possible, the nearest hospital of my choice for evaluation and treatment by an attending physician on duty.
3. **PATIENT BILL OF RIGHTS AND RESPONSIBILITIES** **PATIENT/GUARDIAN INITIALS:** ___________
   The undersigned affirms he/she has received a "Your Rights" Booklet, a patient handbook, which includes patient rights information and patient responsibilities and that these rights have been explained to them in a manner that they understand. The undersigned further agrees to all of the terms and conditions identified in the patient handbook.
4. **PATIENT SEARCHES** **PATIENT/GUARDIAN INITIALS:** ___________
   I understand that the hospital requires that all persons being admitted to CCH and their possessions be searched for items which may be considered dangerous to patient safety and the welfare or safety of others and hospital employees. The physician may order a more extensive search if deemed necessary.
5. **PATIENT REPONSIBILITES** **PATIENT/GUARDIAN INITIALS:** ___________
   The patient/guardian shall indemnify the hospital for any loss, damage or injury caused by him/her while at the hospital. The hospital reserves the right to discharge any patient for the following misconduct: destruction of hospital property, possession and/or sale of drugs, contraband or alcohol, inappropriate sexual conduct, refusal to comply with hospital programs, abuse of therapeutic pass privileges, or any criminal behavior of any kind. Discharge for misconduct will be reviewed by administration before final decision.
6. **LOSS OF PERSONAL PROPERTY / MONEY / VALUABLES** **PATIENT/GUARDIAN INITIALS:** ___________
   The undersigned releases CCH from any liability for the loss or damage of personal property and money kept in the patient's room during his/her hospitalization. I understand that the Hospital will provide safekeeping for my money and valuables and give me a receipt for them. If I do not want to deposit my money and valuables for safekeeping with the Hospital, the Hospital will not be responsible for losses which may occur during my stay.
7. **UNCLAIMED PROPERTY** **PATIENT/GUARDIAN INITIALS:** ___________
   When a patient is to be discharged, it is the responsibility of CCH staff to ensure that all patients receive their property upon discharge. If a patient's item(s) are found after discharge, CCH staff will attempt to identify the patient to whom the article(s) belong and contact them via telephone or letter. Arrangements should be made to collect the item(s) within 30 days of notification. Any unclaimed property that is not retrieved within 30 days of receiving notice will be discarded accordingly.
8. **RESPONSIBILITY FOR DESRUCTION OF PROPERTY** **PATIENT/GUARDIAN INITIALS:** ___________
   The undersigned understands that patients are responsible for any damage to or destruction of CCH property or property belonging to others which may be located at CCH. The undersigned agrees to accept liability for and reimburse CCH or other owners of property which the patient damages or destroys while at CCH.
9. **USE OF PHOTOGRAPHY AND SURVEILLANCE EQUIPMENT** **PATIENT/GUARDIAN INITIALS:** ___________
   The undersigned consents to the taking of photograph(s) for the purpose of identification. The photograph(s) may be permanently retained in the patient's medical record. In addition, it is understood that there is the use of surveillance equipment for monitoring to provide added security within the facility. The undersigned also understands that the patient's privacy will be maintained within the use of this material.
10. **PATIENT SAFETY** **PATIENT/GUARDIAN INITIALS:** ___________
    The undersigned agrees that CCH will not be responsible for the safety of care of the patient if the patient leaves the premises without permission and will indemnify CCH from any losses or injury which may occur as a result of leaving against medical advice.
11. **PRIVACY PRACTICES / RELEASE OF INFORMATION** **PATIENT/GUARDIAN INITIALS:** ___________
    I hereby authorize CCH and my physicians to release medical, psychiatric, and substance abuse information contained in my/the patient's medical record to any necessary insurance carrier(s) and/or other representatives of legal and regulatory agency(s), (i.e. The Joint Commission, AHCA, and CMS) for the purpose of obtaining information and/or reviewing the record for quality and medical care received by the patient and for the payment of all hospital and medical charges. Unless noted below, medical records released may include psychiatric, HIV, or substance abuse treatment information. Withhold from release: (please specify, if any)

CEDAR CREEK HOSPITAL of Michigan

Patient Label

Federal law/regulations and HIPAA guidelines protect the confidentiality of patient records, specifically in the areas related to alcohol and drug abuse. CCH will not disclose information to anyone outside of CCH which would identify any patient as an HIV, alcohol, or drug abuser unless the following parameters are met: the patient has consented in writing to disclosure, the information is requested by a court order, or the disclosure is made to medical or another qualified personnel in accordance with said regulations. Any records that are being released to the patient's provider of care will be done at no charge to the patient/resident. The patient may request and sign a consent and authorization to release information authorizing CCH to release specified patient information, including specific information regarding diagnosis, treatment, and prognosis with respect to any physical, psychiatric, and/or alcohol/drug condition for which the patient is being treated, including but not limited to CCH employees, attending physicians, and/or other healthcare professionals or organizations. The patient will be responsible for costs associated with the copying of medical records and may revoke the authorization at any time. Treatment is not contingent upon signing of the release of information. The initialing of this section indicates the receipt and understanding of HIPAA guidelines for Privacy Practices.

12. **FINANCIAL REPSONSIBILITY** **PATIENT/GUARDIAN INITIALS:** ____________

a. I guarantee payment to the Hospital of its charges for treating the patient named below and in connection with this guarantee of payment; I will authorize and consent to a credit inquiry by the Hospital. I understand and agree that the patient's bill must be paid in full upon discharge unless a claim for insurance benefits has been filed or unless the Hospital agrees to accept monthly payment on the bill. I FURTHER UNDERSTAND AND AGREE THAT ANY CHARGES NOT PAID BY INSURANCE ARE MY FINANCIAL RESPONSIBILITY and if this account is referred to an attorney or collection agency for collection that I shall pay the attorney's fees, court costs, and collect expenses in addition to any judgement.

b. If any insurance or third party coverage, which the patient may have, rejects the patient claims or pays only part of the claim, the undersigned shall be responsible for payment of the balance due, as determined by CCH.

13. **ASSIGNMENT OF BENEFITS** **PATIENT/GUARDIAN INITIALS:** ____________

In consideration of hospital and medical services rendered by CCH, to the extent permitted by law, I hereby irrevocably assign, transfer, and set over to CCH, all of my rights, title, and interest of medical reimbursement, including but not limited to the right to designate a beneficiary, add dependent eligibility, and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate, or other health benefit indemnification agreement otherwise payable to me for those services rendered by CCH during the tendency of the claim for the admission. Such irrevocable assignment and transfer shall be for the recovery on said policies of insurance but shall not be construed to be an obligation of CCH to pursue any such right of recovery. I hereby authorize the insurance company(s) or third party payers to pay directly to CCH all benefits due for services rendered.

The undersigned further authorizes CCH to release information for the purpose of obtaining pre-authorizations for treatment and concurrent review and to release that information to medical review agencies, and/or third party payers providing coverage or having responsibility for this admission. In addition, a representative from my payer may visit me during my hospitalization.

14. **PHYSICIAN SERVICES & PROFESSIONAL SERVICES BILLING** **PATIENT/GUARDIAN INITIALS:** ____________

The undersigned acknowledges that the patient is under the care of an attending physician(s) while they are a patient at CCH. Some physicians may be employees of CCH. The undersigned recognizes that certain healthcare professionals furnishing services to the patient, including but not limited to, radiologists, pathologists, psychiatrists, psychologists, physical therapists, and/or licensed social workers may be independent contractors and may not be employees or agents of CCH. Physicians and licensed medical staff extenders are not located in the facility 24 hours per day. The facility has a psychiatrist and medical physician/licensed extender on call at all times to address medical issues promptly. The undersigned recognizes that the consent(s), assignment(s), guarantee(s), and release(s) herein shall apply to such other providers and services. The undersigned further recognizes that the patient may be billed separately by their attending physician and/or other healthcare professionals for their professional services.

15. **OTHER CONSENTS, ACKNOWLEDGEMENTS, RELEASES** **PATIENT/GUARDIAN INITIALS:** ____________

a. I acknowledge that my cooperation in my plan of treatment is required

b. I agree to comply with and obey the rules and regulations of the hospital.

I HAVE READ, UNDERSTAND, AND AGREE TO THE CONDITIONS OF ADMISSION. I GIVE MY CONSENT TO HOSPITAL CARE AND I ACCEPT FINANCIAL REPSONSIBILITY.

Patient Name **Guardian Name**

Patient Signature **Date** **Guardian Signature** **Date**

Witness Signature **Date** **Time**