PATIENT NAME: _____ **DATE OF ADMISSION/SERVICE**_____

PATIENT IDENTIFIER (DATE OF BIRTH): _____

MEDICAL CONSENT

I voluntarily and knowingly request and consent to the inpatient/outpatient services which may include medical treatment, x-rays, blood tests, laboratory tests, and other diagnostic tests deemed appropriate by any physician(s) or other health care provider(s). I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of care, treatment or examination. In addition, I understand and agree that this consent for treatment will extend to the hospital should I necessitate an admission to the hospital during or following my outpatient procedure.

I understand and consent to testing for HIV (Human Immunodeficiency Virus – AIDS), hepatitis, and/or other blood borne agents posing occupational risk may be performed on me if a health care professional, or first responder (police, firefighter, paramedic, etc.) sustains an exposure to my blood or other bodily fluids. I understand that Michigan law permits this testing, and should such testing occur, I will not be billed for it.

I consent to the disposal of any specimens or tissue taken from my body during my hospitalization and/or treatment. I further consent that any form of visual media of me may be taken during the course of treatment and may be used for teaching purposes. I further consent to the presence of and treatment by medical residents who are physicians in training at Sparrow Hospital.

I understand that these consents include the use of information that may be related to drug or alcohol abuse, psychiatric care, HIV testing, AIDS (Acquired Immune Deficiency Syndrome), HIV infection or ARC (AIDS Related Complex) and may include social worker/client communications and psychologist/client communications.

INITIAL HERE _____

FINANCIAL CONSENT

Financial Agreement: I understand that Sparrow Hospital and those health care providers (including physicians) who are under contract with Sparrow Hospital or who otherwise provide services to patients of Sparrow Hospital ("Health Care Providers") submit claims to insurance carriers as a courtesy to patients. I understand that I am responsible for the balance owed to Sparrow Hospital or Health Care Providers after Sparrow Hospital and/or Health Care Providers have billed my insurance carrier(s). I understand that the physician services I received (including attending and consulting physicians, surgeons, anesthesiologists, radiologists and pathologists) are usually hired separately and that both Sparrow Hospital and any attending and consulting providers may bill me separately. I agree to pay for all services rendered to me without regard to any benefit limitations imposed by any insurance carrier, unless prohibited by law or contract. In addition, unless other arrangements are made in advance, I agree to pay my account in full after I receive services and to pay any legal fees and interest at the legal rate, which results due to my not paying the balance. I understand that neither Sparrow Hospital nor Health Care Providers accept liability for failure to meet any pre-certification required by my insurance carrier, and I agree to pay for all services if pre-certification is denied by my insurance carrier. I consent to Sparrow Hospital's use and disclosure of my health information to any person or organization that is legally or contractually responsible for payment of my bills for the services I received. I also consent to Sparrow Hospital's disclosure of my health information to attending and consulting providers for billing purposes.

Assignment of Benefits: I hereby assign to Sparrow Hospital and Health Care Providers all of my insurance and managed care benefit due to me for services rendered to me by Sparrow Hospital and/or Health Care Providers. I authorize my insurance company and/or my managed care company to make payment directly to Sparrow Hospital and/or Health Care Providers.

PATIENT NAME: _____ **DATE OF ADMISSION/SERVICE**_____

PATIENT IDENTIFIER (DATE OF BIRTH): _____

Physician Billings: I understand that the physician services I received (including attending and consulting physicians, surgeons, anesthesiologists, radiologists and pathologists) are usually hired separately and that I may be billed separately by both Sparrow Hospital and any attending and consulting providers. I consent to Sparrow Hospital disclosure of my health information only to attending and consulting providers for billing purposes.

INITIAL HERE _____

VALUABLES RELEASE

I understand and agree that Sparrow is not responsible for my valuables, personal belongings or any property kept in my possession or in my room while I am a patient at Sparrow Hospital. I declare that I do not need and therefore, decline valuable safekeeping services as provided by Sparrow Security Dept. I hereby release Sparrow from any responsibility for loss of or damage to any personal property or money kept in my possession or in my room while I am a patient.

INITIAL HERE _____

I understand that any aspect of this Consent and Release Form that I do not understand can be explained to me in further detail by asking my physician(s) or health care provider or their associates. I certify that this Consent and Release Form has been explained to me or that I have read it or have had it read to me, and that I understand its contents.

_____
Printed name of patient or patient's representative

_____ _____
Signature of patient or patient's representative Date

Complete the following ONLY if patient or representative signs by use of a mark:

_____
Printed name of witness

_____ _____
Signature of witness Date

_____
Print name of witness

_____ _____
Signature of witness Date

If the above signature is that of a patient's representative, Sparrow must complete the following

Sparrow has verified the identification of _____(patient's representative name) by_____ (type of verification, e.g., driver's license) and that in his/her capacity of _____ (description of authority to act, e.g. legal guardian, patient designated personal representative, power of attorney for medical care including medical records, executor of estate).

Verification completed by: _____ _____
Associate Name & Signature Date