Holland Hospital

Treatment Consent/Payment Agreement/Privacy Practice Acknowledgement

Consent for Treatment

Knowing that I require (or the patient for whom I am signing requires) diagnostic testing, medical treatment, or hospitalization at Holland Hospital (or one of its satellite locations) or one of the Holland Hospital physician practices (collectively, HH), I do hereby voluntarily consent to such testing and treatment by the HH medical staff and employees as deemed necessary in their judgment. If I am an obstetrical patient, I understand that my signature also consents to the care and treatment of my newborn.

You may consent to general medical care, tests, or medical procedures without being required to consent to HIV testing for medical diagnostic and/or treatment purposes. You may decline HIV testing for medical diagnostic and/or treatment purposes at any time before administration of the test by making your wishes known to your healthcare providers. You may request that your diagnostic-/treatment-related HIV testing be handled anonymously.

Notice: You are hereby notified, pursuant to Michigan law, that as a patient of this facility, you may be tested for the presence of HIV, an HIV antibody, Hepatitis B, and Hepatitis C without your consent if any health professional or other health facility employee sustains a needle stick or mucous membrane or open wound exposure to your blood or any other body fluids. This test is permitted by Michigan law and is for your protection as well as the protection of the physicians, nurses, and other employees of the hospital.

I hereby consent and grant to HH the right and authority to record my image, which could occur in connection with my diagnosis, treatment and care, and which is being created to ensure the safety of patients, visitors, and staff and the quality of said services. I further agree that upon creation, such recordings are owned by HH. I understand that I have the right to request cessation of recording or filming at any time. I agree to release and forever discharge HH, its agents, officers and employees from any and all claims arising out of or in connection with the use of these images and/or recordings, including, but not limited to, any claims for invasion of privacy, right to publicity or defamation.

Release of Information

In the event that HH needs to give or receive information or service, I agree that HH may give information in the medical record about me to any person involved in my medical care, including any information about abuse treatment, mental illness, HIV infection, acquired immunodeficiency syndrome, and related complex venereal disease or tuberculosis to any third party responsible for paying for my care, including, without limitation, records relative to claims, my employer, and any workers compensation insurance carrier engaged by my employer and to any outside peer review or auditing agency engaged by a third-party payer to review my medical records.

No Representations or Guarantees

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no oral or written representations, guarantees, or promises have been made to me as to the results of any diagnosis, treatment, and medical care that I (or patient) may receive as a patient at HH.

I understand that many of the physicians on the staff of HH, including my attending physician(s), may not be employees or agents of HH, but rather, may be independent contractors who have been granted the privilege of using its facility for the care and treatment of their patients (for example, radiologists, anesthesiologists, pathologists, emergency physicians). As such, HH exercises no control over the medical decisions regarding the diagnosis and treatment, nor the personal performance of services by the physician(s). See "Assignment of Benefits & Other Benefit and Considerations" below.

Personal Property

I hereby relieve HH of any responsibility for loss of clothing, money, valuables, dentures, glasses, or any other personal items. It is understood that money, jewelry, and other valuables, at my request, may be placed in the hospital safe at the time of admission or service.

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Teaching, Research, and Quality Improvement

I understand that HH operates and/or supports teaching programs for health care professions and participates in approved medical/nursing research. I consent to approved students collaborating in the observation of my medical care, examinations, procedures, surgery, and/or treatment as well as the review of my medical record(s) and diagnosis for purposes(s) of promoting optimum student teaching and training. I understand that data from my medical record may be reviewed, analyzed, and/or reported in a group format without my personal identification for the improvement of HH operations, educational programs, and patient care quality. I understand some research projects may require my additional approval and any identifying information will not be published without my prior consent. I understand that my dignity and right to confidentiality will be preserved and I have the right to consent or decline my participation at any time.

Assignment of Benefits and Other Benefit and Considerations

Where "I" is used in this agreement, it refers to both the Patient and the Patient's representative or agent. HH has no duty to investigate the authority of the Patient's representative or agent and is relying on the representation of the Patient's representative or agent that he or she has the authority required to enter into this agreement.

I agree to the following:

1. I assign to HH all rights to benefits, insurance proceeds, settlement payments, or judgments to which I may be entitled for HH services. I agree that I want HH to bill my insurance directly and request that any payment for insurance be made directly to HH. I certify that the insurance information given by me is correct. I understand that if I choose not to have my insurance company billed for the services I receive that I will be considered "self-pay" and will be responsible for all charges. **I understand that I am responsible for any HH balance not paid by insurance.**

2. HH utilizes ancillary services providers, including, but not limited to, radiologists, pathologists, anesthesiologists, and emergency physicians. These providers may or may not participate with my insurance plan. I understand that it is my responsibility to secure determination of my insurance coverage related to any ancillary service providers. I assign all rights to benefits, insurance proceeds, settlement payments, or judgments to which I may be entitled for doctor's services in connection with the interpretation of Laboratory, Pathology, Radiology, Neurology, Cardiology, diagnostic tests, Anesthesiology, and/or Emergency Room/Urgent Care Services to the doctor or organization furnishing services and/or authorize such doctor or organization to submit a claim for payment on my behalf to the insurance carrier.

   I understand that the ancillary provider(s) will bill me separately for its charges and any amount due after insurance will be billed by and due to the ancillary provider(s).

3. I understand that some insurance companies require prior authorization for procedures. It is the patient's responsibility to check with his/her insurance company prior to the visit for any prior authorization requirements to avoid insurance denials or higher deductibles/co-insurance payments.

4. I agree, in order for HH to service my account or to collect any amounts I may owe, that HH and its Business Associates and Covered Entities/Service Providers may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which may result in charges to me. In addition to the reasons stated above, HH and its Business Associates and Covered Entities/Service Providers may also contact me by sending text messages or e-mails, using any e-mail address I have provided to HH for purposes of communications, fundraising efforts, and other reasons. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I acknowledge I was given the opportunity to review and receive a copy of HH's "Notice of Privacy Practices." I know that I can ask questions about the information in the notice and that I can ask for a copy of the Notice to take with me.

By signing below, I acknowledge that I have read, understand, and agree to the terms of this Holland Hospital Treatment Consent/Payment Agreement/Privacy Practice Acknowledgement.

Signature of Patient/Patient Representative or Agent	Relationship (if other than patient)	Date
Print Name (if other than patient)	Witness	Date