BRONSON	Affix Patient Label
	Patient Name: Date of Birth:

Outpatient Diagnostic Testing and Office Visits
General Consent to Treat and Registration Release Form

I Agree To:

- Treatment by my care team.

I Agree That:

- I will ask questions. No one has made promises about my treatment or care.
- Medical students or staff may look at my treatment and medical records for teaching or research. Information about me will not be published unless I agree in writing.

I Understand That:

- I have rights and responsibilities when I receive services. Information about my rights and responsibilities have been given to me.
- The staff will double-check who I am. They will ask what I am having done. I know this is to keep me safe.
- Bronson uses an electronic health record system that allows my healthcare information to be shared with other healthcare providers who need access to my information. They will use this information to provide and manage my care.
- My doctor may change my care to improve my life or health.
- My doctor may work with other doctors I have seen either in the past or present.
- I understand that some doctors, Radiologist and Pathologists doctors, are not employees of Bronson. They are responsible for the care they provide.
- An HIV (AIDS virus) test or other blood test may be done without my consent after someone who has helped in my care is exposed to my blood or other body fluids. An example of this would be a skin cut.
- For safety reasons, my person and my belongings might be searched if there is a sound belief I may have items or substances that could harm others or me.
- All diagnostic specimens obtained in the office (ex: laboratory, pathology, cytology) will be sent to Bronson Hospital for processing unless otherwise notified by the patient. My insurance company can verify if the tests are a covered benefit or not.

Medical Information: I understand Bronson may release my medical records to:

- Insurance companies, health plans and claims processers.
- My doctor(s) and others involved in my care.
- My employer, if the services are requested by my employer or related to a Workers Compensation claim or another work-related incident.
- A person or entity responsible for paying all or a large portion of my bill.
- Attorneys and their Agents (including Bronson's) in response to a legal order or other legal process.
- Courts, as may be necessary to obtain payment of my bill or in response to a court order.

"Highly Confidential Information," including information about drug or alcohol abuse, mental illness, HIV or related illnesses has special privacy protection under state or federal laws and will not be released without a separate written authorization form.

Assignment of Rights: I give to Bronson Healthcare Group, all rights to bill and obtain payment for services I receive or have previously received through the date I signed this assignment. I give Bronson all rights to payment of my bills. This means that Bronson can, for example:

- Send my bills to insurance companies and health plans and communicate with them for the purpose of receiving payment.
- Appeal the denial of payment or an adverse benefit decision.
- File a lawsuit to receive payment of a bill.

- File on its own or join as a party any lawsuit or proceeding which involves my bill. This includes pursuing all costs, interests, penalties and attorney fees allowed by law.
- I give up all rights to settle, release or keep monies for my Bronson Healthcare Group bill. I give up the right to take any action which would compromise payment or reimbursement of my Bronson Healthcare Group bill.

My Other Authorizations and Agreements:

- I agree to help Bronson Healthcare Group or Bronson approved agents working on my behalf with the pursuit of insurance benefits, insurance coverage, or a payment source. I will provide Bronson Healthcare Group with my home and/or cell telephone numbers.
- I agree, in order for Bronson to settle my account or to collect any amounts I may owe, Bronson Healthcare Group may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges. Bronson may also contact me by sending text message(s) or e-mail, using the e-mail address I provided to Bronson. Methods of contact may include pre-recorded/artificial voice messages and the use of an automatic dialing service, as applicable.
- I name Bronson Healthcare Group my representative authorized to pursue payment of my bill and appeal the denial of payment or an adverse benefit determination, and to file a lawsuit to obtain payment.

My Responsibility for Payment:

- I understand that I am personally responsible for payment of my Bronson Healthcare Group bills.
- I confirm the information I give to Bronson Healthcare Group is correct and I agree to provide Bronson all insurance information and all financial information regarding my ability to pay.
- I understand it is my responsibility to ensure any required authorization for treatments provided by a specialist is provided before the visit. If authorization is not received before the scheduled visit, I understand I will need to pay the fees myself.
- If my primary care doctor is not a Bronson Healthcare Group Physician, I am responsible to get any required authorization from my primary care physician or health plan and forward to Bronson Healthcare Group. If authorization is not received before treatment, I will be financially responsible and need to pay fees myself.
- If my insurance company has a Contract for Services with Bronson that covers my care, my personal financial responsibility to Bronson may be limited to what is determined to be not covered by and payable under that contract. I will be notified by Bronson of any balances that remain my responsibility after any insurance payments are applied.
- If my insurance company does not have a Contract for Services with Bronson, I will need to pay for all Bronson charges not covered by my insurance. If there is a difference between Bronson's charges and the amounts paid by my non-contracted insurance company, I am responsible for paying the difference.
- If I do not have health insurance, I must pay Bronson Healthcare Group for all charges from Bronson Healthcare Group for my care.
- I understand I am responsible for:
  - Co-payments
  - Deductibles
  - Non-Covered Charges
  - Some Medications
- I understand I will receive monthly billing statements if I owe money to Bronson after my services. The statement will include pending insurance payments as well as any balance that is due from me. The amount due from me is expected to be paid in full within 30 days from getting the billing statement and balances over 120 days, will be sent to collections. I understand that I am responsible for all costs of collection, including court costs and reasonable attorneys' fees.
- I understand I may be billed for both physician and facility charges for services rendered, even for services provided on the same day.
- I understand I may get *separate bills* from Anesthesiologists, Radiologists and Pathologists. I understand I am responsible for paying these bills if they are not covered by my insurance. Bronson has no responsibility to pay these bills.

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- A charge of $25.00 will be charged for all returned checks. Patients are responsible to pay this charge by credit card, money order or in cash upon receipt of a statement.
- For patients under 18 (minor), the parent, guardian, or unaccompanied minor acknowledges responsibility for the terms of this General Consent to Treat and Registration Release Form.
- If at any point, you are unable to pay your statement balance, Bronson Healthcare Group has payment options available for you.
    - *Please reach out to a financial counselor or call **269-341-6117** with any questions.*

If any provision of this General Consent to Treat and Registration Release Form is held invalid by any court, I agree that the remaining provisions shall remain valid.

I have read and understand this form. All of my questions have been answered. If the patient is a minor (18 years or younger), the parent or guardian must sign the below.

Changes or alterations to this form are not binding on Bronson Healthcare Group/or its affiliated entities.

Patient Signature: _____ Date: _____ Time: _____

Parent or Guardian Signature: _____ Date: _____ Time: _____

Relationship to Patient: _____

Witness Statement: I obtained verbal consent via phone from parent/guardian. Two staff witnesses are required.

Witness Signature: _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____ Time: _____

Interpreter's Statement:

I have interpreted this consent form to the patient, a parent, closest relative or legal guardian.

Voice/Video Service: _____ Interpreter ID #: _____ Date:_____ Time:_____

Interpreter Name *(printed)*: _____ Agency: _____

Interpreter Signature: _____ Date:_____ Time:_____