BRONSON
Battle Creek

Affix Patient Label

CONSENT FOR TREATMENT: I request and consent to care and treatment as my physician considers necessary. I authorize the performance of diagnostic tests, lab tests, X-rays, and other medical or surgical procedures recommended by my physician. I consent to admission to the Hospital and to permit the admitting physician, physicians consulted regarding my treatment, nurses, technicians, students, and other persons who work at the Hospital, to provide the necessary care and services to me. I consent to Hospital producing or using recordings, films, or other images, using any media, for the provision of healthcare. I understand that my authorization will be obtained prior to the production or use of recordings, films, or other images, using any media, for purposes other than for the provision of healthcare. I understand that if I do provide such authorization that I may provide a written revocation at any time before the use of the images.

DISCLOSURE OF MEDICAL INFORMATION: I understand Bronson Battle Creek (hereafter "BBC") may use and disclose information about me for treatment, payment, or healthcare operations purposes. I understand there are instances where information can be disclosed by BBC without my prior authorization: when required by law including, but not limited to, for reporting communicable diseases, reporting abuse and neglect or reporting for public health or worker's compensation purposes. BBC has an electronic medical record (EMR). Your Battle Creek EMR may be accessed by Bronson providers at other Bronson locations. This will be for treatment purposes.

NO GUARANTEE OR PROMISE OF RESULTS AND THE HOSPITAL'S RIGHT TO DISCHARGE: I understand the practice of medicine is not an exact science and acknowledge that no one has or can give me a promise or guarantee of what the results of my medical treatment and care will be. I understand that my admission and continued hospitalization is based upon my physician's determination of my need for services and treatment. I agree that nothing in this Consent prevents the Hospital from discharging me immediately if I violate Hospital policies.

PHYSICAL ENVIRONMENT AND PERSONAL BELONGINGS: I recognize the Hospital has a right to search my person or my belongings at any time for the safety and protection of myself and other persons at the Hospital. I understand that no one may have or bring into the Hospital any illegal drugs or alcoholic beverages, toxic substances, dangerous articles or weapons of any type. If brought to the hospital, I know the items will be confiscated and that person may be prosecuted and/or discharged from the Hospital. I understand the Hospital is not responsible for any loss or damage of my personal property or valuables. I know the hospital has a place to keep my valuables. I understand I should have all valuables deposited with the Hospital or sent home for safekeeping. If this is not done, the Hospital cannot be held responsible for any loss or damage to my valuables.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment of insurance benefits (including Medicare and Medicaid) to be made directly to
BBC. I understand that I am financially responsible to BBC and attending physicians for services in all circumstances such as: a) I am a managed care participant where prior approval is necessary by my primary care physician and/or the managed care organization for payment. b) I have a worker's compensation injury where prior approval is necessary by my employer for payment. This includes claims authorized today and later held in litigation by me or my employer. c) I am a participant of a non-contracted insurance carrier where BBC is under no duty or obligation to seek payment before requesting full or partial payment from me.

d) I am not covered by insurance and/or the services provided by BBC are not covered by my insurance carrier. I understand I will receive Physician billing separate from the hospital bill.

RELEASE OF INFORMATION TO PAYORS: I authorize BBC and any physician who treats me while I am a patient at the hospital to release necessary information to the responsible person or organization, or which the hospital reasonably believes may be responsible for the payment of my hospital bill. I also understand that information relating to drug and/or alcohol abuse, psychiatric treatment, HIV/AIDS may be released to parties responsible for payment of my Hospital bills. If I am transferred to another facility, copies of my medical records will be released for continued care. I also agree the Hospital may release my social security number, if applicable, to manufacturers for the purposes of tracking implanted medical devices. This authorization is effective for as long as may be necessary to obtain payment from third party payors or until I revoke it in writing.

FOR MEDICARE RECIPIENTS ONLY: "I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize a holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediaries or carriers or to the Professional Review Organization any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf."

TRICARE: If I am eligible for Tricare benefits, I acknowledge I have received a copy of the "Important Message from Tricare."

RECIPIENT RIGHTS ACKNOWLEDGEMENT: I understand that I have certain rights that are explained in the written materials that have been provided to me during the registration process, when appropriate. By signing below, I document that my rights as a recipient of services have been provided and explained to me.

SMOKE-FREE CAMPUS: I am aware that use of tobacco products on BBC property or properties maintained by BBC is prohibited.

I HAVE READ THIS FORM (OR HAVE HAD IT READ TO ME) AND I UNDERSTAND AND AGREE THAT, BY SIGNING THIS FORM, I AM BOUND BY WHAT IT SAYS WHETHER I AM THE PATIENT OR SOMEONE ACTING ON THE PATIENT'S BEHALF. I ALSO ACKNOWLEDGE BY MY SIGNATURE THAT I HAVE BEEN OFFERED THE "IMPORTANT INFORMATION" PACKET.

X _____ _____ _____
Patient Signature (or other person acting on Patient's behalf) | Date | Time

_____
Relationship to Patient if signed on Patient's behalf

_____ _____ _____
Witness Signature | Date | Time

BRONSON Battle Creek	Affix Patient Label

SPECIAL NOTICES

EMANCIPATED MINORS can authorize their own medical treatment. Please provide written documentation of the emancipation.

IF A MINOR IS NOT EMANCIPATED by the court system, a parent or legal guardian must sign this consent form, in most situations. There are some treatments available to minors, in the State of Michigan, which do not require parental consent. For any questions or concerns related to minor consent, please do not hesitate to speak with our registrar.

HIV TESTING AFTER OCCUPATIONAL EXPOSURE OF HEALTHCARE PERSONNEL
Occasionally personnel at Bronson Battle Creek (BBC) may experience accidental exposure to your blood or body fluids during your care. This exposure may place the caregiver at risk of infection; therefore, in accordance with Michigan Public Health Code, if a health professional or facility employee of BBC sustains a percutaneous, mucous membrane or open wound exposure to your blood or other body fluids, a blood test will be performed on you to determine your HIV status.

SERIES PATIENT INFORMATION
Patient authorization and re-consent will be required if the course of treatment is substantially changed.

CHEMICAL ADDICTION PATIENT INFORMATION
The confidentiality of alcohol and drug abuse patient records maintained by BBC is protected by Federal law and regulations. Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records maintained by BBC. Generally, BBC may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:

a. The patient consents in writing
b. The disclosure is allowed by a court order
c. The disclosure is made to medical personnel in a medical emergency or to qualified personnel or research, audit, or other program evaluations

OTHER PATIENT INFORMATION
Federal law and regulations do not protect any information about a crime committed by a patient or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse and neglect from being reported under State law to appropriate State or local authorities.

For any questions or concerns, please speak with your registrar or phone the BBC Patient Relations Representative by dialing extension 58333 from within the hospital or dialing (269) 245-8333 from an outside line.