

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Facility's Notice of Privacy Practices describes the specific meanings of "treatment", "payment", and "health care operations" and how the Facility may use and disclose my health information to carry out these functions. I acknowledge that I have been offered a copy of the Facility's Notice of Privacy Practices.

Signature of Patient (Relationship, if not patient) Date

Reason acknowledgement could not be obtained: _____

AUTHORIZATION FOR TREATMENT AND FOR RELEASE OF MEDICAL INFORMATION

I _____; DOB ___/___/___ know that I have a condition requiring medical treatment at Mercy Family Care, and/or emergency medical treatment. I voluntarily consent to all procedures, hospital care, and treatment deemed necessary by my physician(s), the medical staff, and other health care professionals of the Facility identified on the opposite side of this form and hereinafter referred to as the "Facility".

I am aware that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks. I acknowledge that no guarantees, assurances or warranties, oral or written, have been made by anyone as to the results of my care and treatment.

I understand that the Facility will use and disclose my health information that identifies me to carry out treatment, payment, and health care operations. I understand that this health information may include reference to mental health, substance abuse or immunodeficiency illnesses (HIV, AIDS, and ARC).

ASSIGNMENT OF INSURANCE BENEFITS / PAYMENT FOR SERVICES

I request payment of Medicare benefits or other insurance benefits due me or on my behalf be made directly to the Facility for any services furnished me, including physician services. I understand that the services of physicians and other healthcare professionals may be billed separately from those of the Facility. I understand that I am responsible for any health insurance deductibles and coinsurance amounts, and I understand and agree that this assignment does not relieve me of my obligation to pay my medical and hospital bills if they are not paid by the insurance company. I certify that all the information given for payment of my medical and hospital bills (including information required under the Medicare and Medicaid programs) is correct. I agree that venue for all disputes regarding payment of my bill from the Facility is the county in which the Facility is located, and that I am responsible for the Facility's actual cost of obtaining payment if collections or court costs are necessary.

ACKNOWLEDGEMENT OF HIV (HUMAN IMMUNODEFICIENCY VIRUS) TESTING LAW

Michigan Law permits an HIV test to be performed upon me if a health worker or first responder is exposed to my blood or other body fluids under his or her skin, in an open wound, or through his or her mucous membrane while treating me before, during or after transport to the Facility. If this type of exposure occurs (or the HIV test is performed pursuant to the request of a first responder under Michigan law) then I understand that my blood can be tested for HIV without my consent.

Medicare Patients: I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services (CMS) and its agents in order to determine these benefits or the benefits payable for related services.

I have read and understand each of the above authorization, acknowledgement, and information sections or have had them read and explained to me.

Signature of Patient (Relationship, if not patient) Date

To be initialed by the legal representative in the case of a minor or of an adult without the capacity to make his or her own decisions regarding medical treatment. I certify that I am the legally appointed representative of this minor or incompetent adult and acknowledge that I am legally responsible for payment of my dependent child's medical bills.

_____ Initials

Signature of Witness Date

Reason patient is unable to sign at the time of registration: _____