Holy Family Healthcare

Consent for Services

Patient Name_____ **Date of Birth**_____

AUTHORIZATION FOR TREATMENT:
I authorize Holy Family Healthcare to provide treatment to myself or the above named patient.

NOTICE OF PRIVACY PRACTICES:
I have been given a copy of Holy Family Healthcare Privacy Practices in compliance with HIPAA legislation.

ASSIGNMENT OF BENEFITS:
I authorize my insurance company to pay and hereby assign directly to Holy Family Healthcare, all benefits, if any, otherwise payable to me for services. This authorization may be revoked by either me or my insurance company at any time in writing.

REFERENCE LABORATORY SERVICES:
I understand that Holy Family Healthcare utilizes the services of an outside lab to perform some of the lab tests requested by its physicians. I further understand that the Reference Laboratory will bill separately for its services. I consent to Holy Family Healthcare providing demographic information as necessary for billing purposes.

CANCELLATION OF APPOINTMENTS
I understand that I must give a 24 hour notice to cancel my appointment. I further understand that future services may be denied if I fail to keep my scheduled appointments.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:
I authorize release of copies of pertinent medical records to providers outside of Holy Family Healthcare who are being consulted with and/or I am being referred to in connection with my current treatment, to insurance companies for the purpose of determining benefits for services provided, and to reference laboratories for billing purposes.

AUTHORIZATION FOR RELEASE FOR RESEARCH OR QUALITY IMPROVEMENT:
Michigan Law requires us to inform you that a copy of your medical record, no matter when created, may be released to outside groups for medical research or quality improvement purposes unless you object. Researchers cannot use patient names or identifying characteristics when reporting any results of their research. We evaluate these requests to ensure that the release of patient records is necessary to accomplish the research purpose.

PAYMENT AGREEMENT/COLLECTION POLICY:
I, the undersigned, do hereby expressly guarantee payment of all charges for medical services rendered, or to be rendered by Holy Family Healthcare. I understand that it is my responsibility to provide Holy Family Healthcare with current insurance information. I understand that a finance charge of 8% per annum is charged to any balance 60 days or older on my account. I will be responsible for the balance due, plus incurred by Holy Family Healthcare, in collecting my account.

NON VIOLENCE POLICY
I understand that Holy Family Healthcare is committed to providing its employees with a safe, nonviolent workplace and determine whether particular conduct violates this policy or is otherwise

USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION
•My insurer may share my past, current and future health and account records with Holy Family Healthcare about services I've received from Holy Family Healthcare and other care providers unrelated to Holy Family Healthcare These records may be used by Holy Family Helathcare as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

•_____My insurer MAY NOT RELEASE any of my identifiable health records from providers unrelated to Holy Family Healthcare, for the purposes described above.

By signing this form, I am consenting to treatment and agreeing to these policies. I understand this authorization will remain in effect until I revoke it in writing.

_____ _____ _____
Date Signature Patient (if 18 yr.) / Parent / Legal Guardian Relationship to Patient