Lake Huron Medical Center

1. CONSENT TO MEDICAL CARE AND TREATMENT

I am being treated at (*Physician's office)* **Dr. Gaurav Bhalla** and I consent to all medical and surgical care, examination and tests determined by my physician that are necessary for me. Though I expect the care given well meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I DO NOT follow my physician's recommendations as they may related to my health that the physician and this office will not be responsible for any injuries or damages that are the result of my Noncompliance. I understand that if an employee or individual associated with the Physician office is exposed to my blood or body fluids, I will be tested for hepatitis viruses and the Human immunodeficiency Virus, (HIV). I also understand that I receive education related to this testing and that I will not be charged for testing and education related to the exposure.

2. CONSENT TO USE OF INFORMATION

Electronic Health Records: I understand that the Physician office may collaborate with other health care providers to coordinate, manage, and provide health care to me, and I consent to the Physician office sharing my health information and records electronically for the purposes of treatment, payment, and or operation, including improving the overall quality of health care services provided to me (e.g. avoiding unnecessary or duplicate testing, etc.). I consent to the inclusion in the electronic health records of sensitive diagnosis and related information such as HIV/AIDS status, sexually transmitted disease, genetic information, and mental health and substance abuse, ect..The electronic health records (EHR) will be accessible to LAKE HURON MEDICAL CENTER system credentialed Physicians/Practioners as well as other individuals approved to access EHR for the purposes related to treatment, payment, healthcare operations and/or other purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act (HIPPA). The Physician office has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my medical information as required by HIPPA.

Use and Disclosure of Information: In addition to the above consent to use and share my health information with the Prime Healthcare system, I agree that the Physician office may use and disclose my health information for a range of purposes including: treatment, eligibility, verification, and/or payment to private and public payers or there agents including insurance companies, managed care organizations, my employer, (If I am injured by work), state and federal government programs, Worker's compensation programs, obtained pre-admission or continued length of stay certification, quality of care assessment and improvement activities, evaluations, the performance of qualification of physician's and health care workers, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory, and accreditation requirements and public health and health oversight services.

Request for Information from Others: I consent to the Physician Office's request of my health information form other providers of care to me, receipt of and release of my health information, whether written, verbal or electronic, for the uses described above as well and the Physician office's participation in any health information exchange described in the Physician Office Notice's of Privacy Practices (NPP). Please refer to the NPP for additional, detailed information regarding the uses and disclosures of protected health information

3. ACKNOWLEDGEDMENT OF RECEIPT OF NOITICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of Physician Office Notice of Privacy Practices which provides information on how the Physician Office may use or disclose PHI for purposes or treatment, payment por health care operations.

*** ** * PLEASE INITIAL_____ * * ***

4. ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to the Physician Office for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.

5. FINANCIAL RESPOINSIBILITY

I understand that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided, or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid, or other insurance or payers (e.g., services rendered by healthcare providers who do not participate with my insurance plan.) Non-covered services also may include those services my Physician I determines to be medically necessary but are later determined unnecessary by the payer. ~ Account balances sent to the Credit Bureau a second time will result in discharge from LAKE HURON MEDICAL GROUP (LHMG).

6. **PERSONAL VALUABLES**: I understand that the Physician Office does not accept responsibility for any lost, stolen, or damaged personal items while I am at the Physician Office.

Printed Patient Name:_____ Date of Birth: _____

Patient Address/City/State/ Zip Code

_____

Signature of Patient (or Patient's Legal Representative)

_____ Date: _____

(if legally represented fill out below) * * *

* * Printed Name of Patient's Legal Representative: _____

* * Relationship of Legal Representative (e.g. Parent, Guardian, Other) _____