DMC DETROIT MEDICAL CENTER

☐ CHM ☐ KEI
☐ DRH ☐ RIM
☐ HUH ☐ SGH
☐ HVSH ☐ HEART
☐ HWH ☐ _____

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Patient Label

OUTPATIENT GENERAL CONSENT FORM

PATIENT'S NAME _____

1. **CONSENT:** I consent to routine medical, nursing care including routine procedures, examinations, tests, immunizations, regional and local anesthesia, series of treatments/procedures and other treatment by (Dr.) _____ and his/her assistants, associates or consultants as is necessary in their judgment. I realize that _____ is a teaching facility affiliated with various universities including but not limited to Wayne State University and Michigan State University, and consent to medical care being performed by students, residents, physician extenders or medical support staff who are supervised by experienced doctors and nurses. I know if I have any questions about my care or tests, I should be sure to ask the doctors/nurses/staff about them. I know it is up to me to tell the doctors/nurses/staff about any health problems or allergies I have. I must also tell the doctors/nurses/staff about drugs or medications I am taking. I consent to the testing and disposal of specimens of my blood, urine and other bodily fluids, tissues and products. I consent to HIV testing having received verbal explanation and education materials regarding HIV testing; I understand that an HIV (human-immunodeficiency virus) and/or a HBV (hepatitis B virus) or HCV (hepatitis C virus) test may be done upon me without my further consent if a doctor, health professional or employee sustains a percutaneous, mucous membrane or open wound exposure to my blood or other bodily fluid.

2. **ADDITIONAL CONSENT FORMS:** I understand that for certain procedures deemed necessary by my physician(s), I will be required to sign a special consent form. Further, if I do not fully understand a procedure or its risks, consequences and alternative methods of treatment, I have the right to question the appropriate health care professionals.

3. **RELEASE OF INFORMATION:** The DMC releases patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in our HIPAA Notice of Privacy Practices.

4. **INSURANCE:** I authorize the doctor and the staff to review my insurance coverage with my insurance company. I authorize payment of my insurance benefits to be made directly to the doctor. I agree to pay in full any and all charges not covered by insurance or other benefits. I understand that providers may bill separately.

5. **NO GUARANTEES:** I understand that the practice of medicine is not an exact science and that no guarantees or promises have been made to me as a result of treatments or examinations by the doctors or assistants. I understand that no contract, warranty, guarantee, or promise concerning the results of medical service is made. This consent to treatment form is not a contract, nor is it an offer to contract, nor is it an acceptance of an offer to contract.

6. **PERSONAL PROPERTY:** I understand and agree that the Detroit Medical Center shall not be liable for the loss or damage of any personal property which may or may not be given to Detroit Medical Center staff during my stay in one of their institutions.

7. **NOTICE OF PRIVACY PRACTICE:** I have received a copy of the Detroit Medical Center's Notice of Privacy Practices. I understand that additional copies of the notice will be provided to me upon my request.

I CERTIFY THAT ANY AND ALL INFORMATION PROVIDED BY ME IN FURTHERANCE OF MY APPLICATION FOR HEALTH CARE BENEFITS ARE TRUE. I HAVE READ THIS FORM. IT HAS BEEN FULLY EXPLAINED TO ME, AND ALL OF MY QUESTIONS ABOUT THE FORM HAVE BEEN ANSWERED. I UNDERSTAND ITS CONTENTS.

PATIENT SIGNATURE	Date/Time	Patient's Personal Representative's Signature	Date/Time
WITNESS	Date/Time	Representative's Authority To Act / Relationship To Patient	

ADVANCE DIRECTIVES

What is an Advance Directive?

An Advance Directive is a written document which authorizes someone you know and trust to make health care decisions for you when you are unable to do so. You are not required to have an Advance Directive, nor can your family or insurance company force you to have one.

What is a Durable Power of Attorney for Health Care?

In Michigan, you can complete a Durable Power of Attorney which appoints another adult to act as your personal representative. If you are unable to communicate with your healthcare team, your Durable Power of Attorney will allow your personal representative to make the following types of decisions on your behalf:

- To have access and control of your medical information;
- To employ and discharge physicians, nurses, therapists and any other care providers, and to pay them for their services;
- To give informed consent or an informed refusal on your behalf with respect to any medical care; diagnostic, surgical or therapeutic procedure; or other treatment of any type or nature; including life sustaining treatments such as artificial nutrition and hydration;
- To execute waivers, medical authorizations and such other approval as may be required to permit or authorize care that you may need, or to discontinue care that you are receiving;
- To make decisions that could or would allow your death.

Your advocate will be guided in making his/her decisions based upon your wishes as you've made known to him/her, and you may specifically record those wishes on the Durable Power of Attorney. For more information concerning advance directives please speak with the Office Manager.

PATIENT PRIVACY

The privacy of your personal health information is protected by both state and federal law. The Health Insurance Portability & Accountability Act (HIPAA) is the federal piece of this protection. HIPAA is intended to give you rights over your health information. HIPAA sets rules and limits on who can look at and receive you health information.

What information is protected?

- Information your doctors and nurses put into your medical records
- Conversation with you or about you concerning your condition or treatment
- Information about you in the hospital's computer systems

For more specific information on how the DMC protects your health information, please refer to our *Notice of Privacy Practice,* copies of which are available at the Admitting Department and is posted throughout our hospitals and clinics.

PATIENT RIGHTS & RESPONSIBILITIES

As our patient, you have both rights and responsibilities when it comes to your health care. To better understand what your rights and responsibilities are, talk with your health care provider, or review a patient bill of rights and responsibilities brochure or poster located throughout our health system's facilities.

SMOKING

The Detroit Medical Center, its hospitals and grounds are designated Smoke Free facilities. We encourage the cessation of smoking. If you have any questions or concerns regarding smoking, or need information regarding the cessation of smoking, please see your health care provider.