Completing the General Consent, Treatment and Release of Information Form

The General Consent, Treatment and Release of Information form is considered a legal document informing the patient of treatment. All patients/guardians of patients (or legal representatives) receiving services at Corewell Health must sign a consent form annually. The form is normally presented at the time of registration.

To view the consent form, go to the Documents and Forms webpage and see the **Consent General, Treatment and Release of Information** form (English version is located under the Patient Care section, while translated versions are located under the **Clinical Language Services** section).

Terms and Definitions

Term	Definition
Adult Patient	Anyone 18 years of age or older
Minor Patient	Anyone under the age of 18
Encounter Level Scan	Document is only valid for that specific encounter.
Patient Level Scan	Document is valid for one year

Staff Responsibilities

When collecting the signature on the consent form, employees must:

- Present all pages of the **General Consent, Treatment and Release of Information** form to the patient/guardian or legal representative to review.
- Obtain a signature from the patient/guardian or legal representative of the patient.
  - For more information on how to discuss the consent form with the patient, see **General Consent Form Scripting**.

- Verify that consent for a minor has been signed appropriately by reviewing the annual consent document.
  - If the minor patient has a **General Consent, Treatment and Release of Information** on file, and the other parent/legal guardian brings in the minor for treatment, a second **General Consent, Treatment and Release of Information** will need to be signed.
  - If guardianship has changed, a new **General Consent, Treatment and Release of Information** form will need to be signed.
- Sign as a witness and include date/time only when the form is printed, and a signature is not obtained electronically (employee signatures must be legible).

NOTE: All four pages of the General Consent, Treatment and Release of Information form must be scanned into Epic when an electronic signature is not used.

Who May Sign Consent?

Adults

- Patient – always the first choice.
  - Patient must be competent and not under the influence of drugs/alcohol.
  - If patient is competent but physically unable to sign, must obtain a verbal consent from patient. Two Beaumont employees MUST witness.
- Legal Representative
  - Guardian – a court appointed guardian (legal guardian) may sign only if proof of guardianship documentation is presented. The documentation issued by the court must be copied and scanned into the patient record.
  - Advocate as designated by the patient on Durable Power of Attorney/Patient Advocate for Health Care documentation. The document must be copied and scanned into the medical record (original returned to patient).

Minors

- Parent or legal guardian (with proof of guardianship) must sign for minors.
  - NOTE: Grandparents and stepparents may not sign unless they are legal guardians or have power of attorney from the parents.
- Exceptions:
  - Legally married (legal documentation/marriage certificate provided).
  - Time period when serving in the Armed Forces (legal documentation/military ID provided).
  - Court order of emancipation (legal documentation/court order provided).
  - Seeking treatment for suspected pregnancy/pregnancy related matters.
  - Seeking care related to substance abuse.
  - Seeking care related to physical abuse in the home.
  - Seeking care related to sexually transmitted diseases.
  - Minor mother may sign for her child.
  - Minor over 14 years of age may consent to OP mental health services.

Interpretation Services

Per policy and Joint Commission, obtaining informed consent is considered a clinical situation. Family members or employees cannot be used to translate a Consent form. When the patient's preferred language is not English, the patient or appropriate representative needs to be provided with either a translated Consent form or access to an Interpreter Service (MARTTI, Cyracom or In-Person Interpreter).

The Consent form is available electronically in Epic in both English and Spanish. The form is available to be printed in the following languages: Spanish, Burmese, Swahili, Kinyarwanda, Vietnamese, and Arabic. These translated versions can be accessed via the Documents and Forms webpage on the Beaumont Intranet (located under the **Clinical Language Services** section).

If interpretation services are used, a paper copy of the consent **must** be printed.

When interpretation services are used, the interpreter must:

- Document the time (use either Traditional "8:00 AM" or Military "0800" format)
- Document his/her signature on the **Interpreter signature** line (if in person)
- Print his/her name on the **Interpreter name (print)** line.

If using an over-the-phone or video interpreter, employees must:

- Print the interpreter's name (if BH interpreter) or the interpreter's ID number (if using a vendor's phone agency interpreter) on the **Interpreter name** line.
- Document in parentheses that interpretation services were provided via phone or video.

INTERPRETATION SERVICES

I certify that I have interpreted, to the best of my ability, into and from the participant's stated primary language, _____, all oral presentations made by all of those present during the informed consent discussion.

TIME _____ ☐AM ☐PM **DATE** _____ Interpreter signature _____

Interpreter name (print) _____

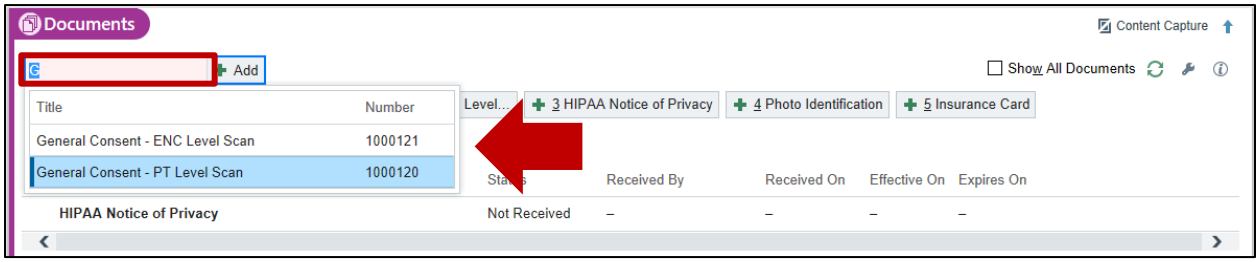
If a patient denies interpreter services:

- The patient will need to complete the **Wavier of Hospital Offered Free Interpreting Services** form and it must be scanned with the General Consent.
- An interpreter must be present until the patient completes the waiver form.
- Even if a patient signed a waiver, providers have the discretion to keep a qualified interpreter present during the interaction to ensure accuracy and competency of information delivered, especially when dealing with high level clinical issues.

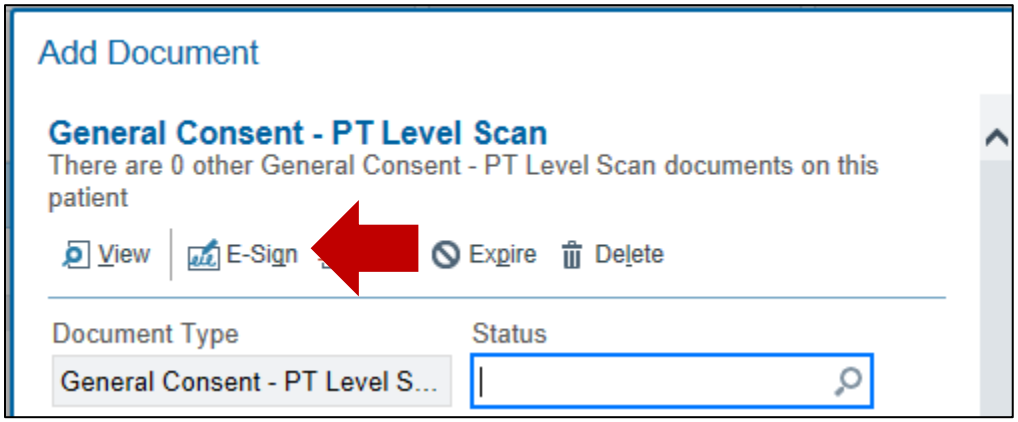
Methods of Signing Consent

Electronically Signing Consent:

1. Select the appropriate **General Consent** type from the Documents table.



2. Select the **E-Sign** icon to open the **E-Signature Document Collector** window.

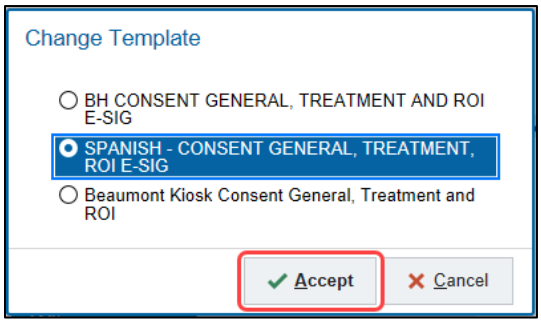


3. Explain the General Consent to Treatment and Release of Information consent form to the patient. Please see the **General Consent for Treatment and Release of Information Scripting** Job Aid for additional information.

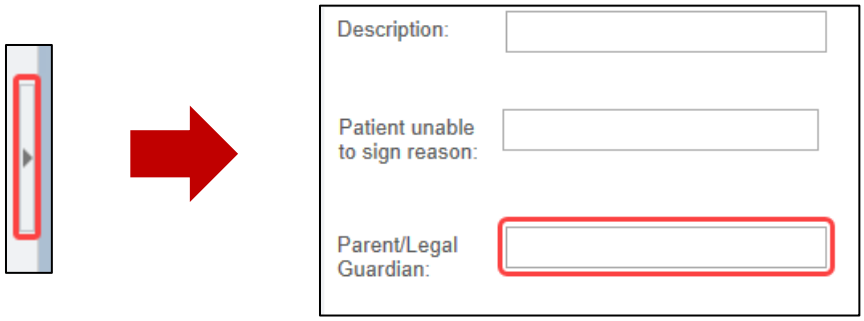
NOTE: This document is available in English and Spanish. To change the language:

- Click **Change Template** in the lower left-hand corner.

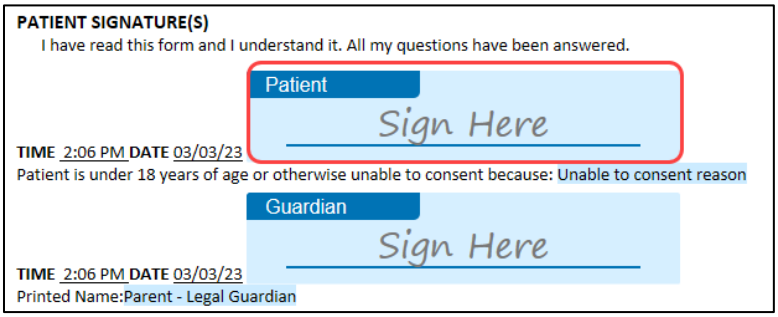
- Click the radio button next to the consent form with the language needed.
- Click **Accept**.



4. If applicable, click the arrow on the left side of the window to open the side bar. Enter the parent or legal guardian's name in the **Parent/Legal Guardian** field.

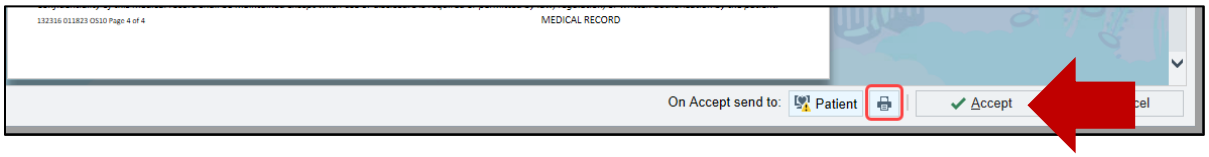


5. Click the appropriate signature box in the **Patient Signature(s)** section.
   - **Patient** signature is for patients who sign for themselves.
   - **Guardian** signature is for when a parent or legal guardian signs for the patient.



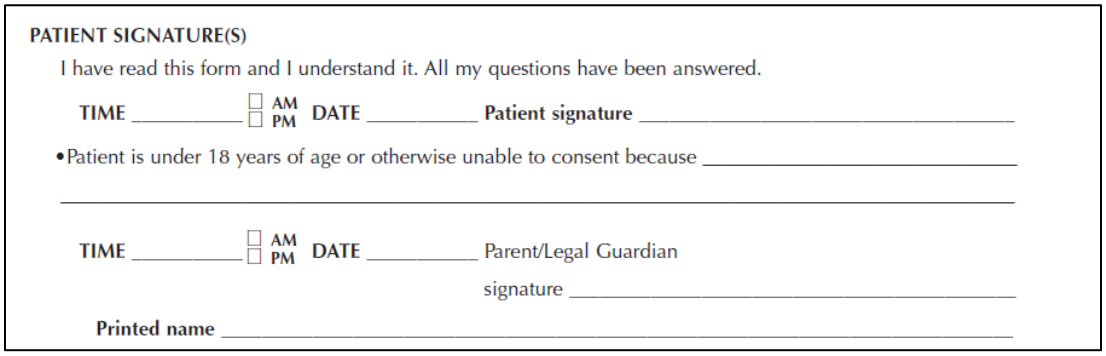
   - A signature window will appear.
6. Instruct the patient or parent/legal guardian to *sign on the Topaz device*.
7. Once the signature is captured, click **Accept**.

8. **Staff Signatures** are <u>NOT required</u> unless the patient is signing verbally, as the user's name and date/time is automatically captured when the electronic signature is obtained.
9. Click the **Printer icon** if the patient requested a copy after it was offered.
10. Click **Accept** if the patient does not need a copy



Signing a Printed Consent Form:

- In the **PATIENT SIGNATURE(S)** section, **only the legal guardian** of the patient can sign the consent form. This may include the patient as their own legal guardian. In this case, the patient would sign the **Patient signature** line.
- If the patient is not their own legal guardian, the appropriate individual would sign on the **Parent/Legal Guardian signature** line and print his/her/their name on the **Printed name** line.



PATIENT SIGNATURE(S)

I have read this form and I understand it. All my questions have been answered.

TIME _____ ☐ AM ☐ PM DATE _____ **Patient signature** _____

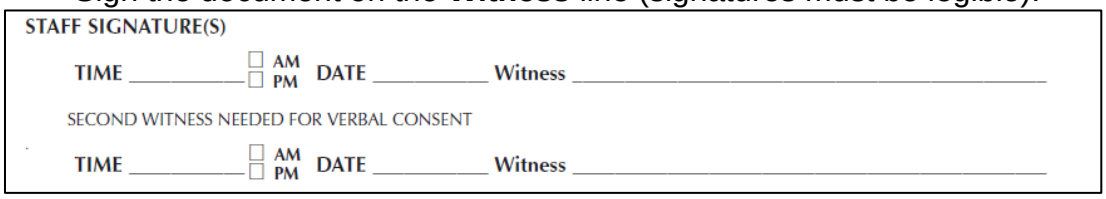
•Patient is under 18 years of age or otherwise unable to consent because _____

_____

TIME _____ ☐ AM ☐ PM DATE _____ Parent/Legal Guardian signature _____

Printed name _____

- In the **STAFF SIGNATURE(S)** section, an employee must:
  - Write the time and date in the **TIME** and **DATE** fields.
  - Sign the document on the **Witness** line (signatures must be legible).



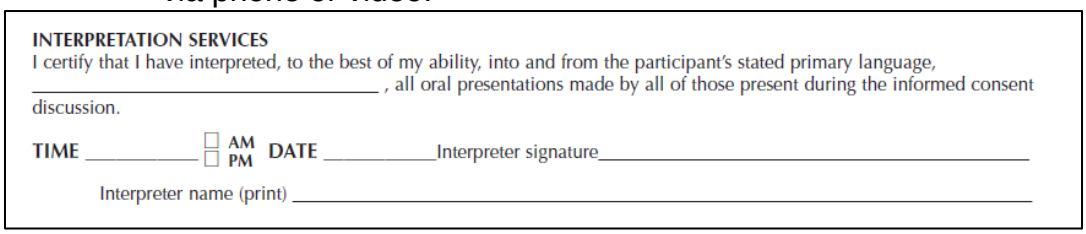
STAFF SIGNATURE(S)

TIME _____ ☐ AM ☐ PM DATE _____ **Witness** _____

SECOND WITNESS NEEDED FOR VERBAL CONSENT

TIME _____ ☐ AM ☐ PM DATE _____ **Witness** _____

- The **Interpreter Documentation** section is only used when an interpreter service is necessary to complete the Consent form.
  - When an in-person interpreter is used for a visit, the interpreter must:
    - Write the time and date in the **TIME** and **DATE** fields.
    - Sign the document on the **Interpreter signature** line.
    - Print his/her/their name on the **Interpreter name (print)** line.
  - If using a phone or video interpreter, an employee must:
    - Write the time and date in the **TIME** and **DATE** fields.
    - Write the interpreter's name & ID number on the **Interpreter name** line
    - Document in parentheses that interpretation services were provided via phone or video.



INTERPRETATION SERVICES

I certify that I have interpreted, to the best of my ability, into and from the participant's stated primary language, _____, all oral presentations made by all of those present during the informed consent discussion.

TIME _____ ☐ AM ☐ PM DATE _____ Interpreter signature _____

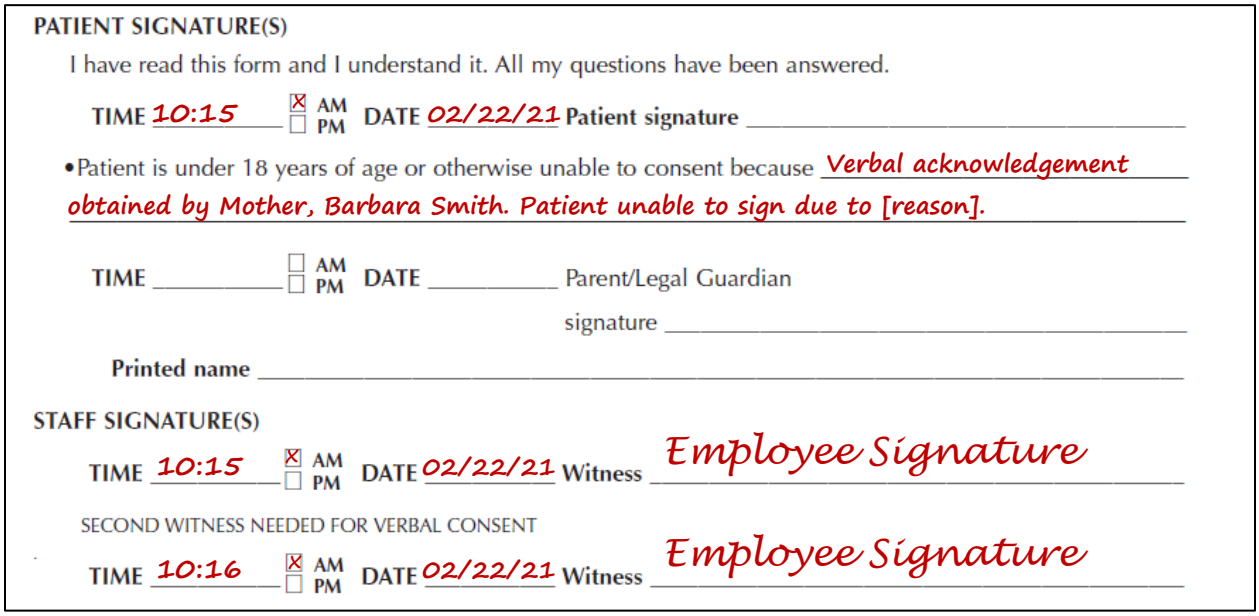
Interpreter name (print) _____

Verbal Consent (Phone OR In Person):

Verbal consent may be obtained via phone if the parent, legal guardian, or patient advocate is not on site at the time service is provided.

Verbal consent in person may be necessary when the patient is not able to physically sign but is capable of granting consent on their own behalf.

- Two employees must participate in a verbal consent
- The entire form must be read to the patient, parent, legal guardian, or patient advocate by one employee while the other employee listens
- Once verbal approval is given, BOTH employees must print the form and document:
  - Verbal acknowledgement obtained by [Self or Parent/Legal Guardian]. Patient unable to sign due to [description of reason].
  - Date and time
- Both employees sign in the Staff Signature(s) section



PATIENT SIGNATURE(S)

I have read this form and I understand it. All my questions have been answered.

TIME 10:15 ☒ AM ☐ PM DATE 02/22/21 Patient signature _____

• Patient is under 18 years of age or otherwise unable to consent because Verbal acknowledgement obtained by Mother, Barbara Smith. Patient unable to sign due to [reason].

TIME _____ ☐ AM ☐ PM DATE _____ Parent/Legal Guardian signature _____

Printed name _____

STAFF SIGNATURE(S)

TIME 10:15 ☒ AM ☐ PM DATE 02/22/21 Witness Employee Signature

SECOND WITNESS NEEDED FOR VERBAL CONSENT

TIME 10:16 ☒ AM ☐ PM DATE 02/22/21 Witness Employee Signature

General Consent, Treatment and Release of Information Form Scenarios and How to Document and Scan the Consent

Scenario	How to Document on the Consent	How to Scan the Consent
Patient unable to sign • Adult patient who is temporarily incapacitated. • Patient presents to ED who is unconscious	• Document as **Unable to Obtain,** notating the medical reason patient was unable to sign. • Two employee witness signatures. o Both employees must be 18 years or older • The patient's spouse/family members should **not** sign the consent unless they are the patient's Legal Guardian or Durable Power of Attorney for Healthcare (DPOA-HC). ***NOTE: A DPOA-HC can be found in Patient Contacts listed as Power of Attorney***	• Scan at encounter level
Minor patient presenting for a service they can consent to themselves. • Prenatal or pregnancy related care • Diagnosis and/or treatment of sexually transmitted disease (STD) or sexually transmitted infection (STI) • Outpatient mental health treatment o If over the age of 14 • Substance abuse or drug dependency o Including dispensing naloxone	• Minor patient signs the consent	• Scan at encounter level

Minor parent presents with their own minor child needing care	• Minor parent signs the consent form. ***Note: A patient is not considered to be a minor if they are emancipated.***	• Scan at patient level
Minor patient or incompetent patient present with anyone other than their legal guardian • Grandparent brings child • Stepparent brings child • Sports coach brings child	• Ensure that a written note, authored by the Legal Guardian, is provided, and has the following information included: ○ The date of service. ○ Explanation or clear purpose for the visit. ○ Signature of Legal Guardian. • If no valid note is provided a verbal authorization via telephone must be obtained. o Two employees must speak to the Legal Guardian. ○ Both employees must be 18 years or older o Confirmation of authorization, witness, and documented on the consent form by both employees. ***NOTE: For more information on obtaining verbal consent, please see the General – Obtaining Verbal Consent tip sheet. If a certain individual brings the patient in frequently, offering the Children's Medical Consent form may be helpful, so that a permission letter will not be needed for every visit.***	• Scan **note** under Consents – Other – ENC Level Scan • Scan **consent** at encounter level

Patients with a Guardianship/patients in foster care	• Legal Guardian signs the consent • If patient presents with anyone other than Legal Guardian/Foster Parent, follow Minor patient or incompetent patient present with anyone other than their legal guardian scenario above. • If the Legal Guardian/Foster Parent does not provide the proper paperwork at the time of service, the Patient Access Representative must call the County Probate Court to verify guardianship/foster care status. If after hours assistance is needed, please work with care management/social work. Please reference the Probate County Court Location and Phone Number section. ***NOTE: The foster parent may not always be the Legal Guardian. The paperwork presented by the foster parent must state the services to which they are allowed to signed consent.*** ***Legal documents must be validated at each visit. Patient Access Staff are required to verify that guardianship and/or the guarantor for the patient has not changed.***	• Scan **documents** under Guardianship Report/Form -PT Level Scan • Scan **consent** at patient level

Verbal consent obtained via virtual waiting room process • Patient calls to check in over the phone from the parking lot	• Two employee witness signatures. o Both employees must be 18 years or older. ***NOTE: For more information on obtaining verbal consent, please see the General – Obtaining Verbal Consent tip sheet.***	• Scan at encounter level
Patient refuses to sign the consent form	• Document refusal on form • Follow the process, If a Patient Refuses to Sign the General Consent, Treatment and Release of Information Form, below.	• Scan at encounter level
Patient does not agree with all or part of the consent form and crosses off sections	• Follow the process, What If a Patient Does Not Agree With All or Part of the General Consent, Treatment and Release of Information Form, below. ***Note: Inform the patient that they will be asked to sign a consent at every visit so that Beaumont Health can properly document encounter specific cross offs.***	• Scan at encounter level
Labor and Delivery process for obtaining newborn consent	• No newborn consent is needed. ***NOTE: Mom's consent form will cover the newborn. A consent form for the child will be obtained at the newborns next visit (e.g., new patient visit with PCP)***	• No newborn consent is needed.

If a Patient Refuses to Sign the General Consent, Treatment and Release of Information Form

Refusal to sign the **General Consent, Treatment and Release of Information** form in an emergency department or urgent care setting, will be documented on the form and the charge nurse will be made aware. Treatment decisions will then be handled by the clinical staff. Outside of the emergency department or urgent care setting, Patient Access Staff will contact the provider's office for final treatment decisions and document the decision on the consent.

What if a Patient Does Not Agree With All or Part of the General Consent, Treatment and Release of Information form?

If the patient does not agree with all or part of the consent form, the patient must cross off the information that he/she disagrees with.

For more information on what can be crossed off and how to address these cross offs with the patient, please refer to the **General Consent Form Cross Offs** job aid.

Probate County Court Location and Phone Number

Probate County Court Location	Phone Number
Genesee	810-257-3528
Hillsdale	517-437-4643
Ingham	517-483-6300
Jackson	517-788-4290
Lenawee	517-264-4580
Livingston	517-546-3750
Macomb	586-496-5320
Monroe	734-240-7346
Oakland	248-858-0260
Shiawassee	989-743-2211
St. Clair	810-985-2066
Wayne	313-224-5706

General Consent, Treatment and Release of Information

Beaumont

CONSENT GENERAL, TREATMENT AND RELEASE OF INFORMATION

NOTICE OF NONDISCRIMINATION:
Beaumont Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Beaumont Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex or any other basis prohibited by law.

I AGREE:

- To examination and treatment by providers, residents, students, and other healthcare professionals at Beaumont Health. This may include in-person, shared medical appointment, telemedicine, videotaping, photographing and audio devices. These tools may be used to treat/diagnose or for procedures to be performed for medical, scientific and/or personal safety.
- As discussed and agreed, the provider may change my and/or my child's care to benefit my life or health.
- If I am here to give birth, the provider and other healthcare professionals may give care to my baby.
- If I am participating in a shared medical appointment, I will attend this appointment with other patients. During these appointments, personal information about me may be shared by my provider to others.
- The provider may obtain specimens of my blood, urine and other bodily fluids/tissues ("specimens"). I authorize the provider to retain and preserve these specimens for research, scientific, and teaching purposes as well as perform other tests not related to my diagnosis on these specimens. The provider may dispose of these specimens as it chooses.

I UNDERSTAND THAT:

- I will ask questions.
- I am aware the practice of medicine and surgery is not an exact science. No one has made promises or guarantees to me about the results of my treatment, care, or examination at Beaumont Health.
- Students and staff may see me and look at my medical record for teaching or research purposes.
- The staff will double-check who I am. They will ask what I am having done. This is to protect me.
- Some providers and staff are not employees of Beaumont Health. I know that Beaumont Health is not responsible for their care or other actions. I also know I will receive separate bills from them even though they provide services to me at a Beaumont Health location. I will work with their offices to answer questions about my insurance.
- Michigan law allows healthcare providers to test my blood for HIV (AIDS virus) or Hepatitis without my consent if someone who has helped in my care is exposed to my blood or body fluids.
- A copy of the Beaumont Health Financial Assistance Eligibility Policy is available upon request at all registration areas and on our website at:
  - https://www.beaumont.org/patients-families/billing/financial-assistance (Beaumont Health)
- Beaumont Health will not tolerate discrimination against my provider, other healthcare professionals or staff because of race, color, gender, national origin, age, disability, sex or any other basis prohibited by federal, state or local law.
- Should my condition require referral to a specialist, I understand I will be asked my choice of a provider. I will have the opportunity to have Beaumont Health contact the provider of my choice or if I do not have a preference, an independent provider from Beaumont Health's "on-call" list will be called. I consent to my insurance company billing for professional services given by this provider whether or not this provider participates with my insurance program.
- This consent is valid for one (1) year from the date of my signature.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

132316 011823 C610 Page 1 of 4

MEDICAL RECORD

MY MEDICAL INFORMATION:

- BEAUMONT HEALTH MAY RELEASE MY MEDICAL INFORMATION TO:
  - Insurance companies, health plans and administrators for payment of services I or my child receive(s).
  - Government agencies like Medicare and Medicaid or as required by law.
  - My providers and others involved in my care now or in the future.
  - My employer, if the records are related to care or services paid for by my employer, or for other purposes that are allowed under law.
  - Any person or entity responsible to pay all or part of my bill.
- I agree that Beaumont Health can take my or my child's picture and save it to my electronic medical record. I understand that Beaumont Health will use this picture for identification purposes with the goal of improving patient experience.
- I understand Beaumont Health will keep my or my child's medical information according to state law, federal law and policy. I also understand that my medical information may be stored electronically and may be sent to or received from other healthcare providers and/or payers electronically. This includes my diagnosis (what is wrong with me), treatments (what is being done to make me better), and medicine or prescription information. This will also include any details about my mental health, infectious diseases (like HIV), and other problems like drug or alcohol use disorder.
- I authorize my protected health information (PHI) to be sent to my MyChart (patient portal) account. MyChart is a secure internet portal that allows me to see, receive and manage information about my health.
- I understand my protected health information (PHI) may include very personal information (e.g., physical/mental illness, alcohol/drug abuse, sexually transmitted infections (STIs), HIV/AIDS, etc.). If I give someone access to my MyChart portal or request my PHI be shared with a third-party, that third-party will be able to see my PHI(which may include very personal information). By allowing others access to my PHI, I am agreeing that they can see my very personal information including my HIV/AIDS status.
- In some cases, Beaumont Health is required by law to report medical information to an agency like the health department. This may include information about HIV, TB and other diseases.
- If I am transferred to another facility, Beaumont Health's providers/resident providers may access my medical records to follow up on my care and/or use the information for medical research.

PRIVACY NOTICE

- I have rights and responsibilities when I or my child receive(s) services. I have had the opportunity to receive a copy of the Notice of Privacy Practices and have had an opportunity to ask questions about the information in the Notice.

VALUABLES

- Beaumont Health would like its patients to leave valuables at home or with family members. I agree Beaumont Health is not responsible for safeguarding my property.

PATIENT RIGHTS AND GRIEVANCES

- I understand that I may submit a concern or complaint without fear of reprisal or retaliation. Efforts will be made to resolve my concern promptly or within an appropriate timeframe. If I have questions about my rights as a patient, I may ask questions. The number to call is 947-522-1472. I may also express my concern to the Patient and Family Experience Representative at the location where I receive care.

CONSENT TO CONTACT

- I have given residential and/or cellular telephone numbers and an email address to Beaumont Health. I consent to receive autodialed and/or pre-recorded telephone calls, text messages and/or emails from Beaumont Health and/or its agents/third parties. These communications may include billing. I am responsible for any communication charges from my phone provider(s). This authorization is voluntary. I can still be treated even if I do not give "consent to contact".
- Text messages from Beaumont Health might include the date and time of my appointment, my provider's name, the name and address of the location where my appointment is scheduled, and what I need to know to prepare for my appointment, amounts owed, or limited health information.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

Beaumont

CONSENT GENERAL, TREATMENT AND RELEASE OF INFORMATION Continued

CONSENT TO CONTACT continued

- I authorize Beaumont Health to send unencrypted text messages to the cell phone I have on file in my Beaumont Health medical record. I understand that:
  - Text messages are unencrypted. Health Information sent in an unencrypted text message may be intercepted and seen by others. There are other risks with unencrypted text message including misdirected texts, messages forwarded to others, and messages that are stored on servers that have no security. By choosing to receive your Health Information by unencrypted text, you are acknowledging and accepting these risks.
  - This Authorization is valid until I revoke or withdraw my permission to receive text messages.
  - I may revoke or withdraw this Authorization, except to the extent that action has been taken prior to the receipt of the revocation or withdrawal, by calling 877-471-2422.

AUTHORIZATION TO RECEIVE PAYMENT AND BILLING

- Beaumont Health is authorized to seek payment from any third party and from me. I authorize Beaumont Health to act on my behalf to collect benefits from any third party and endorse checks payable to me and/or Beaumont Health.
- I authorize any insurance company, responsible for payment of my medical care and treatment, to pay Beaumont Health for the services given. I understand that I am responsible for any charges not covered by insurance.
- I request payment due to me of authorized Medicare benefits be paid (on my behalf) to Beaumont Health for any services provided to me by Beaumont Health or in its facilities.
- I agree that if my account is not paid when due, Beaumont Health may retain a lawyer and/or collection agency for collection. I will be responsible to reimburse Beaumont Health for all costs, charges and fees associated with the collection of the amount due. This includes, but not limited to, reasonable interest, legal cost in the event suit is filed and reasonable lawyer fees and/or reasonable collection agency fees including those based on a percentage of the debt.
- I agree the information given by me for payment is correct. I know pre-certification or pre-authorization for services is my responsibility.
- If I do not want Beaumont Health to bill my insurance, I must notify them at the time of service.
- Beaumont Health may obtain a credit report to determine if I am eligible for certain uninsured (self-pay) discounts or financial assistance programs. This will not impact my credit score.
- Divorced Parents of Minor Patients:
  - Beaumont Health's medical record system allows for one parent/legal guardian to be assigned as a guarantor (the individual responsible for paying the bill). Parents are responsible to communicate (between themselves) with each other about payment of any charges not covered by insurance.
- Outpatient Medicare Patients:
  - I know that Medicare rules make me responsible for self-administered medicines furnished to me while an outpatient. Self-administered medicines are typically medicines that I take without professional help but may be administered by Provider personnel in the outpatient setting such as the Emergency Department, outpatient department or in observation. Medicare requires hospitals to bill Medicare patients or other third-party payers for these medicines. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these medicines in accordance with Medicare Drug plan enrollment materials.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

ASSIGNMENT

- I assign Beaumont Health:
  - All benefits, claims, and any and all other rights, including the right to bill and talk to any third party for the purpose of seeking payment, regarding my charges at Beaumont Health.
  - The right to file suit or intervene in any lawsuit or proceeding which involves my charges at Beaumont Health.
  - The right to take any other action to seek payment of my charges at Beaumont Health.
- This assignment includes, but is not limited to, the right to appeal the denial of payment of my Beaumont Health charges from any payer, including any employer-sponsored benefit plan, insurance policy or insurance coverage provided by law or contract.
- I also assign to Beaumont Health, and agree that I waive, any and all rights to settle, release or retain payment of my Beaumont Health charges, or take any other action which would in any way compromise payment or reimbursement of my Beaumont Health charges.
- I also appoint Beaumont health as my authorized representative for the purpose of pursuing payment for my Beaumont Health charges. I authorize Beaumont Health to act on my behalf to pursue any benefit claim, including one under Employee Retirement Income Security Act of 1974, and to appeal an adverse benefit determination. I agree to assist Beaumont Health in the pursuit of all insurance benefits and agree to pay all co-insurance, co-payments and deductibles required by any insurance plan.
- I authorize and direct Beaumont Health to apply the proceeds of any recovery to my Beaumont Health charges.

TRANSLATION

- I understand I can access this document in other languages upon request.

PATIENT SIGNATURE(S)

I have read this form and I understand it. All my questions have been answered.

TIME _____ ☐ **AM** ☐ **PM** **DATE** _____ **Patient signature** _____

- Patient is under 18 years of age or otherwise unable to consent because _____

_____

TIME _____ ☐ **AM** ☐ **PM** **DATE** _____ Parent/Legal Guardian signature _____

Printed name _____

STAFF SIGNATURE(S)

TIME _____ ☐ **AM** ☐ **PM** **DATE** _____ **Witness** _____

SECOND WITNESS NEEDED FOR VERBAL CONSENT

TIME _____ ☐ **AM** ☐ **PM** **DATE** _____ **Witness** _____

INTERPRETATION SERVICES

I certify that I have interpreted, to the best of my ability, into and from the participant's stated primary language, _____, all oral presentations made by all of those present during the informed consent discussion.

TIME _____ ☐ **AM** ☐ **PM** **DATE** _____ Interpreter signature _____

Interpreter name (print) _____

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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MEDICAL RECORD