General Consent Form Cross Offs

The Consent General, Treatment and Release of Information form is used to obtain authorization from and provide information to the patient or the legal representative. To partner closely with patients and treat them as individuals, Beaumont Health will attempt to honor alterations patients wish to make. There are specific alterations to the consent that cannot be fulfilled, as elements are required for Beaumont Health to remain compliant and have proof that the patient or the legal representative have authorized care delivery.

Below are instances in which Beaumont Health is not able to honor patient request for alteration:

- During a medical emergency if the restricted information is needed to provide emergency treatment
- Certain public health activities such as to prevent or control disease, injury, or disability
- Reporting abuse, neglect, domestic violence, or other crimes
- For health agency oversight activities such as auditing, investigations, inspections, and expenditures
- For law enforcement investigations regarding the investigation of criminal activity
- For judicial or administrative proceedings in response to a subpoena, court order or other similar process
- For identifying decedents to coroner and medical examiners or determining cause of death
- For organ procurement
- For research activities
- For workers’ compensation programs
- For uses or disclosures otherwise required by law
- For payment of services provided unless payment for such services has been rendered and accepted as payment in full
- For the Privacy Mandate, as full payment is due at the time of service

The below sections will provide further information on how Registration staff should proceed when a patient crosses off section(s) of the Consent General, Treatment and Release of Information form.

Click the section headers on the Consent General, Treatment and Release of Information document for more information and instructions on what to do if a section is crossed off.
Consent General, Treatment and Release of Information Page One

To go directly to the information or instructions for sections, please click the black boxed headers.
General Consent Cross Offs Information and Instructions

NOTICE OF NONDISCRIMINATION

- This section is informational. Crossing out this section would not impact treatment and care of the patient.

I AGREE

- Regarding videotaping/photographs: this section is specifically related to video/photos that are necessary as part of a treatment plan that clinical staff will discuss with the patient before treatment is provided (i.e., radiology services etc.).
- The purpose of the “As discussed and agreed, the provider may change my and/or my child’s care to benefit my life or health.” statement is to inform the patient that their provider will not change their care plan without their authorization.
- The following items in this section can be crossed off:
  - Examination by a student – Beaumont Health will attempt to honor this, but it may not be possible due to not delaying patient care.
  - Videos/photos request for purposes outside of treatment and diagnosis (e.g., publication, presentations etc.) – this requires a separate consent form to be signed which can be declined at that time by the patient.
    - Clinical staff take care of this piece.
- If this section is crossed off, staff should escalate to leadership in the following order:
  - Supervisor to provide awareness
  - Clinical – Head Nurse for a treatment decision
  - Risk Management, if necessary
- Staff will need to follow the refusal of services process and refer the patient to a clinical staff member.
  - Please see the If a Patient Refuses to Sign the General Consent, Treatment and Release of Information section of the Completing the General Consent, Treatment and Release of Information job aid for more information.
- If the patient is not giving birth or taking part in a shared medical appointment, they can cross these sections off with no additional steps required.
I UNDERSTAND THAT

- This section is informational. Crossing out this section would not impact treatment and care of the patient.
- If the patient crosses off **Students and staff may see me and look at my medical record for teaching or research purposes:**
  - Staff should tell the patient: "*Beaumont Health will attempt to honor this. However, we are a teaching hospital and students will have access to records.*"
  - Registrar must document this cross off with a **Patient FYI flag of Restricted Data.** Registrars should document on the flag that the patient declined general consent to treat and release of information section that states "*Students and staff may see me and look at my medical record for teaching or research purposes.*"
  - Clinical staff should check for a **Patient FYI flag related to consent cross offs.**
- If the patient crosses off **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:**
  - Staff should tell the patient: "*Beaumont Health is unable to honor this request. Certain public health activities such as to prevent or control disease, injury or disability is required to be reported by law. Would you like to speak with a clinical staff member?*"
  - A new consent form without this section crossed off should be signed, otherwise proceed to escalate to leadership.
  - If this section is crossed off, staff should escalate to leadership in the following order:
    - Supervisor to provide awareness
    - Clinical – Head Nurse for a treatment decision
    - Risk Management, if necessary
- If the patient crosses off **"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 section is informational. Crossing off this section would not impact treatments or care of the patient.
  - If the encounter is one in which professional fees may be collected, then inform the patient that payment is due at the time of service.
  - If the encounter is one in which professional fees are collected by the physician’s private office, then staff should tell the patient that we are unable to honor this request.
    - A new consent form without this section crossed off should be signed, otherwise proceed to escalate to leadership.
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 received.
  - 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 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 shared electronically and may be sent to or received from other health care 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.
General Consent Cross Offs Information and Instructions

MY MEDICAL INFORMATION

- This section is informational. Crossing out this section would not impact treatment and care of the patient.
- If bullets 1, 2, 4 or 5 are crossed off under “Beaumont Health may release my medical information to” communicate to the patient that:
  - Their insurance will not be billed (GHP, Medicare, Medicaid, W/C, TPL coverage).
  - Payment is due at the time of service.
- If the patient crosses off, I agree that Beaumont Health can take my picture and save it to my electronic medical record:
  - Inform the patient that Corewell Health East does not take pictures to be saved in a patient’s medical record at this time.
- If the patient crosses off, 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:
  - Staff should tell the patient: “Beaumont Health is unable to honor this request. Certain public health activities such as to prevent or control disease, injury or disability is required to be reported by law. Would you like to speak with a clinical staff member?”
  - A new consent form without this section crossed off should be signed, otherwise proceed to escalate to leadership.
  - If this section is crossed off, staff should escalate to leadership in the following order:
    - Supervisor to provide awareness
    - Clinical – Head Nurse for a treatment decision
    - Risk Management, if necessary
- Patients should not cross off I authorize my protected health information (PHI) to be sent to my MyChart account or I understand my protected health information (PHI) may include very personal information. 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.
  - Beaumont Health cannot prevent the flow of information from Epic to MyChart.
  - If escalation is needed, please reach out to Risk Management at 947-522-3101 or email generalconsenttotreat@SpectrumHealth.org.
PRIVACY NOTICE

- This section is informational. Crossing out any of these sections would not impact treatment and care of the patient.

VALUABLES

- This section is informational. Crossing out any of these sections would not impact treatment and care of the patient.

PATIENT RIGHTS AND GRIEVANCES

- This section is informational. Crossing out any of these sections would not impact treatment and care of the patient.

CONSENT TO CONTACT

- This section is informational. Crossing out this section would not impact treatment and care of the patient. However, it will impact patient satisfaction surveys, appointment reminders and accessing MyChart information via email.
- If the patient crosses off, I consent to receive autodialed, pre-recorded telephone calls, text messages, or e-mails from Beaumont Health, staff must:
  - Document in the Comment box of the Demographics form the patient’s refusal.
  - Contact a supervisor or manager for assistance on updating patient communication preferences. If a supervisor or manager are unavailable, contact Customer Service at 877-471-2422.
  - Inform the patient that removing the email address will impact the communication they receive through the MyChart app.
  - Make a comment for reason regarding no email.
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.

MEDICAL RECORD
General Consent Cross Offs Information and Instructions

AUTHORIZATION TO RECEIVE PAYMENT AND BILLING

- This section is informational. Crossing out either section **would not** impact treatment and care of the patient. Communicate to the patient that:
  - Their insurance will not be billed (GHP, Medicare, Medicaid, W/C, TPL coverage).
  - Payment is due at the time of service.
- If a patient crosses off, “Beaumont Health may obtain a credit report [...]”:
  - Staff should tell the patient: “This *is an automated process for patients who do not have insurance or have applied to financial assistance programs. We are unable to honor this request if you do not have insurance or have applied for financial assistance.*”
- The **Divorced Parents of Minor Patients** section is informational. Crossing out any of these sections would not impact treat and care of 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, discussion. ______________________________, 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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General Consent Cross Offs Information and Instructions

ASSIGNMENT

- This section is informational. Crossing out either section would not impact treatment and care of the patient. Communicate to the patient that:
  - Their insurance will not be billed (GHP, Medicare, Medicaid, W/C, TPL coverage).
  - Payment is due at the time of service.

TRANSLATION

- This section is informational. Crossing out either section would not impact treatment and care of the patient.

PATIENT SIGNATURE(S)

- A signature must be obtained for treatment to be provided.
- If a signature cannot be obtained, please see the If a Patient Refuses to Sign the General Consent, Treatment and Release of Information form section of the Completing the General Consent, Treatment and Release of Information Form job aid.

NOTE: If a patient’s condition (urgent or emergent) does not permit signature or verbal consent, medical care will be provided first, and efforts will be made prior to discharge to obtain a signed form.

- If the patient is under 18 years of age or otherwise unable to consent:
  - On the paper consent form, staff must indicate who is consenting for treatment by circling one of the following options: Parent or Legal Guardian.

STAFF SIGNATURE(S)

- A registrar must sign as a witness for paper forms.
- Epic will automatically add the Epic user’s name and date as a witness for e-signatures.

NOTE: If consent is given verbally, then there must be a second witness documented on the paper General Consent form.
INTERPRETATION SERVICES

- A signature **must** be obtained from the interpreter if interpretation services were provided.
- If using an over-the-phone or video interpreter, staff must document 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.
- Staff must also state in parentheses that interpretation services were provided via phone or video.
- If this part of the consent form is crossed off, the patient or legal guardian is stating that an interpreter is not needed (refusing an interpreter).
  - Inform clinical staff that the patient or legal guardian has refused an interpreter.
  - The interpreter will be present until the **Waiver of Hospital Offered Free Interpreting Services** form is signed, and it must be scanned with the General Consent document.

**NOTE:** For patients completing the Consent General, Treatment and Release of Information document via e-sign or kiosk who express that they wish to make cross offs, staff will need to remove the arrival for the patient and review what sections can be crossed off and significance. Staff will then rescan the crossed off paper Consent General, Treatment and Release of Information form and expire the e-sign or kiosk consent, if present in the Documents table.