GENERAL CONSENT FOR TREATMENT

BORGESS

Authorization for Treatment

I am presenting myself for diagnosis and treatment at Borgess Medical Center ("Borgess"). I hereby authorize the performance of any examinations, treatments and procedures, diagnostic testing (including laboratory tests and x-rays) or other procedures related to any examinations, testing or treatment, which in the judgment of the attending physician or other healthcare provider or any consulting physician, are recommended to me. I understand and agree that, pursuant to the Michigan Department of Public Health Code, Borgess may perform an HIV or AIDS test without my written consent if such test is performed after any physician, nurse, other health professional, or health facility employee sustains a percutaneous, mucous membrane, or open wound exposure to my blood or other body fluids. I further authorize the attending physician or other healthcare provider to retain the services of assistants or designees as is necessary in his or her judgment, whose charges for services may be separate and distinct from those of the physicians or other healthcare providers mentioned above. I understand that Borgess is a teaching hospital, and I specifically consent to residents, medical students or students in other health care disciplines participating or observing my care and treatment. If during the course of my treatment at Borgess, I undergo a procedure requiring the removal of tissue, I hereby authorize Borgess to retain or dispose of such tissue according to its customary practices.

Acknowledgement of No Call/No Show Appointment Policy

I understand that if I am unable to keep a scheduled appointment and do not call at least 24 hours prior to the appointment to cancel, it may result in a missed appointment charge from the practice or department. I further understand they may also decide to discharge me from the practice or department.

Authorization to Pay and Assignment of Insurance Benefits

I hereby assign to Borgess and authorize payment directly to Borgess and its associated Medical Groups of any insurance benefits or other payments by third parties otherwise payable to me but not to exceed Borgess' customary charges for the services rendered to me. I understand I am financially responsible to Borgess for charges not covered by any insurance or other third party payor. In the event I fail to meet my payment obligations, I understand I will be responsible for reasonable costs of collection efforts and any fee assessed by a collection agency.

Release of Medical Information

I hereby authorize Borgess, members of its medical staff and the medical groups with which they are associated (my "health care providers") to furnish to my insurance company, to any agency from which I claim benefits and to billing companies and collection agencies that work for my health care providers any and all information about my medical condition required to obtain payment or reimbursement for services rendered by my health care providers. This authorization extends to any information about communicable diseases and infections such as venereal disease, tuberculosis, HIV, AIDS and AIDS-Related Complex, substance abuse treatment information or psychological, mental health and social services information, which may be included in my medical record. I further authorize my health care providers to release all or any portion of my medical records, or to furnish any information reasonably required for the delivery and coordination of my care, to other hospitals, physicians or other healthcare providers, home health providers, insurance companies or other health care facilities that participate in my care or that may provide care to me.

Release from Responsibility for Patient Valuables

I fully understand and agree that Borgess is not responsible for the safety of any valuables and that I am responsible for all personal property, including but not limited to clothing, electronic devices, etc.

Signature below indicates I have read, understand, and agree to all preceding information.

____________________ ____________________

(Date) (Signature of patient or legal guardian)

____________________ ____________________

(Witness) (If signature is NOT patient, indicate relationship here.)

Patient unable to sign due to: ____________________