Genesee HEALTH SYSTEM
420 W. Fifth Avenue
Flint, MI 48503

CONSENT FOR TREATMENT

I, _____ : _____
INDIVIDUAL'S NAME DATE OF BIRTH

1. voluntarily request and consent to a general coordination of care by the system of care and recovery of Genesee Health System (GHS) and its contracted mental health and addiction providers; and I give permission for the psychiatrist and/or physician treating me and his/her associates, assistants, students, or other professional health care providers under his/her direction and/or included in his/her plan of care; or the staff physician who may be assigned by GHS and his/her associates, assistants, students, or other professionals under his/her direction, to provide treatment and/or services for me at GHS and to provide mental health procedures, services, and administration of medications as deemed necessary and advisable.

   I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me regarding the results of the care and treatment that I have hereby authorized.

2. I authorize GHS to release to any third-party payer, or its representative that may be responsible for payment in my case, or as required by law, such information from my medical records as is necessary in order to receive reimbursement for any billings rendered relating to my treatment, including alcohol and drug abuse records protected under the regulations in 2 CFR, Part 2, if any; and social services records, if any; and psychological services records, if any; including communications made by me to a social worker, nurse, physician, psychologist, rehabilitation staff, or consultants. I also authorize GHS to release to individuals or agencies that may provide services for my care such information from my medical records as is necessary to provide those services. This consent shall be valid only as long as is necessary to obtain payment, and will expire when payment is obtained, or when payer review of my records is completed. This consent may be cancelled at any time, except where I have given permission and treatment had already begun, or the records were released based on my original permissions.

3. Additionally, I understand that if I have not chosen a representative and am unable to give my consent, GHS and/or the system of care may contact and/or share the minimum information necessary required by the Hospital from which I am receiving, or have received, services within the last thirty (30) days, with the next of kin and/or contact person in my record (paper and/or electronic form), which I have given to GHS at any time, so that the Hospital and/or individual, in the event of my death or in case of a life threatening situation or medical emergency, may claim my body; complete, initiate, and/or assist in my burial procedures; and/or treat me in an emergency.

4. I give permission for GHS to apply for benefits on my behalf for covered services rendered by them. I also request that all payments from the agreed third party be made directly to them. I certify that the information I have reported regarding my insurance coverage is correct. I understand that I will be responsible for any bills that are not covered by my insurance, up to my ability to pay.

5. I further understand that Act No. 488, Public Acts of 1988 and the State of Michigan, permits an HIV Antibody Test to be performed upon me, without the written consent generally required for HIV Antibody Tests (AIDS), if a health professional or other health facility employee sustains a percutaneous mucous membrane or open wound exposure to my blood or other body fluids.

6. If this is an outpatient authorization, I further understand that my treatment may require more than one occasion of service; therefore, this consent shall carry full force and effect from the date of signature until I am discharged from further outpatient treatment. I understand that treatment may be rendered at GHS or within the system of care and recovery.

Client Name: _____
DOB: _____
Staff Name: _____
Case Number: _____
Medicaid Number: _____

Genesee HEALTH SYSTEM
420 W. Fifth Avenue
Flint, MI 48503

CONSENT FOR TREATMENT

7. I also agree to allow GHS permission to draw blood for a Hepatitis B test when a GHS employee sustains a percutaneous mucous membrane or open would exposure to my blood or other body fluids.

8. I understand the content and significance of this form, and my questions have been answered.

9. I understand that I may withdraw my consent at any time.

STAFF: CHECK THE FOLLOWING IF APPROPRIATE:

☐ Individual has not signed this form, but has voluntarily agreed to participate in treatment and allow coordination with their primary care provider.
Explain:

☐ Individual is a minor 14 years or older and is requesting outpatient services on their own behalf, excluding pregnancy termination referral services and chemotherapy. Services are limited to 12 sessions or 4 months, per request for service, under Chapter 7, Section 707, of the Mental Health Code.

☐ Individual is unable or unwilling to give permission for treatment.
Explain:

STAFF SIGNATURE/CREDENTIALS	DATE

CONSUMER SIGNATURE	PRINTED NAME	DATE

GUARDIAN SIGNATURE	PRINTED NAME	DATE

Client Name: _____
DOB: _____
Staff Name: _____
Case Number: _____
Medicaid Number: _____