CLIENT CONSENT

1200 Washington Avenue
Bay City, Michigan 48708

Client Name:_____ File Number:_____

Any statement not agreed to may be crossed out and initialed by client or client's authorized representative.

CONSENT FOR CARE

I hereby voluntarily consent to authorized BCHD health care professionals including physicians, nurse practitioners, nurses, medical assistants, social workers, and employees of Bay County Health Department (BCHD) to perform services, procedures and/or treatments as prescribed by my physician or in accordance with BCHD specific program/clinic/service protocol.

I further authorize BCHD to obtain specimens of blood, urine, and other body fluids, tissues or products for the purpose of tests or procedures as deemed appropriate for my care. I realize that if tests are taken for sexually transmitted diseases, reporting positive test results to the Michigan Department of Health & Human services is required by law.

I authorize the use of photographs for the purpose of health care and documentation and transfer to BCHD all rights and interest in such photographs.

I have had the purpose of the program/service explained to me, want to participate, and have reviewed my plan of care (if applicable). I understand the services I am to receive, and understand I can withdraw from participation at any time.

CONSENT TO HIV TESTING

I understand that BCHD may perform an HIV, Hepatitis B and Hepatitis C test upon me without additional written consent in the event a BCHD health professional or designee has a percutaneous, mucous membrane, or open wound exposure to my blood or body fluids. The results of any test(s) will be treated confidentially, but may be disclosed as necessary for care of the health professional or designee at risk for blood borne pathogen infection due to exposure to my blood or body fluids

CONSENT to BILL

I request that payment of the authorized benefits from my health insurance be made on my behalf to BCHD. I certify that the Health insurance information I provided is accurate and correct. BCHD will accept payment from Medicare and Medicaid as full payment for covered services.

In the event the insurance company pays me directly, or if the service is not covered by my health insurance, I or my estate will be fully responsible for reimbursing BCHD.

☐ Services to be billed to my insurance ☐ Services to be billed to me

Bill: ☐ Medicare ☐ Medicaid ☐Blue Cross/Blue Shield
☐ Other Insurance ☐ Sliding Fee Scale

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize BCHD to release by mail, phone, fax, or secure encrypted email and/or to obtain all or any portion of my or my child's health record to or from hospitals, health care providers, insurance companies, service agencies, auditors or others involved in my or my child's care that may be pertinent to the delivery, coordination and evaluation of my/my child's care. This includes all information about my or my child's status related to communicable diseases and infections, sexually transmitted infections (STI), Tuberculosis (TB), Hepatitis B, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), alcohol and drug abuse treatment information, mental health treatment records, psychological services and social services information including communications made by me to a social worker.

CONSENT & AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO OBTAIN PAYMENT

I authorize BCHD and its health care providers to release to any third party payer (Medicaid, Medicare, private health insurance etc.) and their clinical review agencies, or insurance carriers, welfare authority or other person or party responsible for any portion of care that is rendered to me such information from my health records as is required in order for BCHD to receive payment or reimbursement for my treatment, including alcohol, and drug abuse records protected under regulations in 42 Code of Federal Regulations, Part 2 (if any), psychological service records (if any), and social service records (if any). This consent shall be effective only so long as is necessary to obtain payment or retrospective authorization for payment and will expire when final payment has been received. This consent to release medical information is subject to revocation at any time with respect to any drug or alcohol abuse records, except to the extent the information has previously been release in reliance thereon.

This consent can be revoked by the client/client's authorized representative at any time unless the agency has acted in reliance upon its continued effectiveness. Without expressed revocation this consent expires within one year, or (please check) ☐ until no longer enrolled in Children's Special Health Care Services.

☐ **I have received a copy of the Bay County Notice of Privacy Practices**

I have read this consent form or it has been read to me and have had my questions answered to my satisfaction.

_____ _____ _____
Signature of Client or Authorized Representative Relationship Date

Reason for signature of Authorized Representative (instead of Client Signature):_____

_____ _____
Signature of BCHD Representative Date