4800 S. Saginaw St. Flint, MI. 48507 Phone: 810-732-8336 Fax: 810-963-1674

5111 Auto Club Drive. Dearborn, MI. 48126 Phone: 313-749-0370 Fax: 313-447-2234

21230 Dequindre Rd. Warren, MI. 48081 

Phone: 586-354-2530 Fax: 586-620-6036

**Consent, Notices, and Conditions of Treatment**

Thank you for choosing Insight Surgical Hospital to provide for your health care needs. We are committed to providing quality healthcare. The first step in this process is to provide information regarding patient rights, risks and responsibilities. The second step is to obtain consent to treat the patient. The admitting staff can answer any questions you may have in regard to the following agreement.

I agree to the following:

**1) CONSENT TO TREAT:** I consent to the treatment of admission to Insight Surgical Hospital for services or supplies that have been or may be ordered by a licensed professional healthcare provider. I understand that treatment may include but is not limited to: radiological examinations, laboratory procedures, physical therapy, anesthesia, nursing care or medical and surgical treatment. I understand that some procedures may include videotaping or other imaging. I understand that all licensed professional health care providers that render services to the patient are responsible and liable for their own acts, orders and omissions. I acknowledge that the hospital has not made nor can it make a guarantee of the outcome of treatment. **2) OUTPATIENT BASIS ANESTHESIA CONSENT:** I understand that if I am receiving anesthesia, I am required to have a competent companion to accompany me to the hospital, be available during and after my surgery, and that I will be discharged to that person’s custody. A competent adult will remain with me for 24 hours following the procedure.

**3) CANCELLATION NO SHOW FEE:** A minimum of 48 hours of notice is required for cancellation of all appointments. If this notice is not received, you may be charged a penalty of $50 for office visits and/or feedback sessions, and $150 for procedures and/or SCS evaluations, or $250 neuropsych evaluations, not payable by insurance.

**4) FINANCIAL AGREEMENTS:** I agree to pay for all services and supplies rendered to the patient in accordance with the rates and financial policies in effect at the time of service. I authorize an overpayment made on this account to be transferred to any other account balance for which I am responsible. I agree to pay interest fees on any unpaid balance after 60 days of discharge or date of service at a rate not to exceed 18% APR. If this account is assigned to an attorney or a collection agency for collection, then I agree to pay all collection agency fees, court costs, and attorney’s fees. **5) ASSIGNMENT OF INSURANCE BENEFITS:** I assign and authorize payment directly to Insight Surgical Hospital of any healthcare benefits that I am entitled to receive. This assignment will not be withdrawn or voided at any time unless I pay the account in full. I understand that I am responsible for any and all charges not covered by my insurance policy(s). If I am entitled to Medicare or Medicaid benefits under Title XVIII of the Social Security Act, I request assignment of benefits directly to Insight Surgical Hospital.

**6) ASSIGNMENT OF PHYSICIAN BENEFITS:** I am aware that physician services provided by a Radiologist, Pathologist, Anesthesiologist, as well as medical, surgical and emergency care are not billed by the hospital but are billed separately. I understand that I am under the same obligation to those providers as stated in this agreement unless otherwise agreed to in writing with those providers. I authorize payment of any medical benefits for such claims to the appropriate provider.

**7) PERSONAL VALUABLES AND BELONGINGS:** I understand that the hospital maintains a safe location for the protection of valuables. I agree that the hospital is not responsible for the loss or damage of any article or personal property unless they are deposited in the safe location and a receipt issues. **8) BLOOD BORNE PATHOGEN EXPOSURE:** I understand that should an employee sustain a percutaneous, mucous membrane, or open wound exposure to my blood or other bodily fluids, that an HIV, Hepatitis B, or venereal related disease test shall be performed as deemed necessary. **9) ASSESSMENT AND TREATMENT:** Your health information may be used by staff members or disclosed to other care professionals for the purpose of evaluation, diagnosis of health conditions, and providing treatment. For example, results of laboratory test and procedures will be available in your health record to all health professionals who may provide treatment or who may be consulted by staff members.

**10) CONSULTATION AND CASE PRESENTATIONS:** Your *de-identified* health information including but not limited to testing results and social history may be used or communicated to relevant professionals and relevant Insight staff for the purposes of case consultation and presentation. In all cases, your anonymity will be maintained.

**11) LAW ENFORCEMENT:** Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law enforcement investigations, for the protection of yourself and others, and to comply with mandated government reporting, as required by law. In addition, Insight Surgical Hospital is compelled to respond appropriately to any and all court subpoenas. **12) OTHER USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION:** Disclosure of your health information or its use for any purpose other than those listed above requires your specific, written authorization. You may submit a written revocation of the authorization at any time. However, your decision to revoke the authorization will not affect or reverse any use or disclosure of information that may have occurred before you notified us of your decision. **13) ADDITIONAL USES OF INFORMATION:** Your health information may be used by our staff to remind you of your appointment. **14) INFORMATION ABOUT TREATMENTS:** Your health information may be used in order to send you information concerning the treatment and management of your condition. We may also send you information regarding other treatments, options, or related services recommended following your evaluation.

**15) NOTE:** Insight Surgical Hospital and its providers are required by law to protect the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required by law to abide by the privacy policies and practices that are outlined in this notice. **16) INDIVIDUAL RIGHTS:**

• You have certain rights under federal privacy standards. These individual rights include the following:

• The right to request restriction on the use and disclosure of your protected health information.

 • The right to receive confidential communications concerning your medical condition and treatment.

• The right to inspect and copy your protected health information.

 • The right to amend or submit corrections to your protected health information.

 • The right to receive an accounting of how and whom your protected health information has been disclosed.

• The right to receive a printed copy of this notice.

**17) RIGHT TO REVISE PRIVACY PRACTICES:** As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice at your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

**18) REQUEST TO INSPECT PROTECTED HEALTH INFORMATION:** As permitted by federal regulation, we require that any request to inspect the

copy protected health information must be submitted to us in writing. You may obtain a form to request access your records by contacting us directly. **19) REQUEST FOR RESTRICTIONS ON PROTECTED HEALTH INFORMATION:** You have the right to request us to restrict how we use and disclose your protected health information. However, we are not required by law to agree with your requested restriction in certain situations. These situations may include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and/or any uses and disclosures described previously in this notice. However, if we decide to grant your request then we are bound by your agreement. **20) BILLING INFORMATION FOR PATIENTS WHO HAVE APPOINTMENT IN DOCTOR’S OFFICES OR OUTPATIENT CLINICS:** When you receive services in your physician’s office or outpatient clinic, your billing statement will show either a facility and/or treatment room charge under the **Hospital Services** section of your statement. Your billing statement will show services in two categories as noted below:

• **Hospital Services:** covers the use of the room and any medical or technical services, supplies or equipment. The facility and/or treatment room charge will be shown here.

• **Physician and Clinical Professionals:** covers your doctor ‘s services, treatment or procedures

 The facility and/or treatment room charge is the result of Insight Surgical Hospital’s physician offices and outpatient clinics being classified as hospital outpatient departments, also called provider-based\* facilities.

 Provider-based billing applies to all patients, regardless of the type of insurance you have. The way your insurance covers facility and/or treatment room charges will be different, based on whether you have insurance through your employer, some other insurance company or if you are covered by Medicare.

**How this affects you if you are covered by your employer health plan or other insurance (not Medicare):**

The way your insurance company handles these charges will vary based on your health plan. Some insurance companies may apply these charges to your annual deductible. To find out, what will be covered, contact your insurance company. If you have additional questions about this charge, call one of our financial counselors at 810-275-9108.

**How this affects you if you have Medicare:**

• The **Hospital Services** charge(s) will be billed to Medicare Part A.

• The **Physician And Clinical Professionals** charge will be billed to Medicare Part B.

**You will receive two Medicare Summary Notices (MSNs): one for Part A and one for Part B:**

• If you have secondary insurance, we will submit any balance to that insurance company.

 • If your secondary insurance does not cover the remaining balance or if you do not have secondary insurance, the balance will be billed to you. Medicare requires that we give you an estimate of your Part A and Part B charges if you do not have secondary insurance. These amounts may be different, depending on the services you receive. These are the charges that will be billed to your insurance company. Your copay or deductible will be determined based on insurance benefits determined by your insurance carrier.

*(Call Customer Service* **810-732-8336** *or see the financial counselor for additional estimates):*

**Part A:** (Hospital)

**Part B:**

(Professional)

**Part A:** (Hospital)

**Part B:**

(Professional)

|  425.00  |  100.00  |  Joint Injection  |  910.00  |
| --- | --- | --- | --- |
|  425.00  |  300.00  |  Chest X-ray  |  400.00  |
|  |  |  |  |

Office Visit Level 3 100.00

Office Visit Level 5 50.00

*\*Provider-based is a Medicare classification. It means that hospitals have met specific Medicare regulations to have their outpatient doc/ors’ offices and clinics classified as provider based. Most large hospital systems are classified as provider based by Medicare, which results in uniform billing. Provider-based billing applies to all patients, just Medicare patients.* **21) NOTICE TO OUR PATIENTS:** I acknowledge that I have received a copy of the Notice of Patient’s Rights brochure at the time of my admission to Insight Surgical Hospital. I have read and understand my rights as a patient at Insight Surgical Hospital.

**22) NOTICE OF PHYSICIAN OWNERSHIP:** You have selected Insight Surgical Hospital a federally recognized “physician owned” specialty hospital for your health care services. As a patient, you have the right to receive a list of all physician owners in this hospital, upon request. Your physician may or may not have an ownership interest in Insight Surgical Hospital, as not all physicians who practice here have an ownership. If you feel that the services that have been ordered for you are not proper or negatively impacted by physician ownership in the facility, please notify a member of administration immediately.

**A)** Your Physician: Dr. Abid, Dr. Ebenezer, Dr. Edem, Dr. Eldohiri, Dr. Franke, Dr. Gemayel, Dr. Jondy, Dr. Khan, Dr. Masternick, Dr. McDougall, Dr. Rampersaud, Dr. Sarmast, Dr. Schupbach, Dr. Shenava, Dr. Sripada, Dr. Torcuator, Dr. Wadehra, and/or Dr. Yin, **DOES NOT** have an ownership interest in this hospital.

**B)** Your Physician: Dr. Shah **DOES** have an ownership interest in this hospital.

You should be aware that alternative health care facilities may be available to you.

**23) NOTICE OF PHYSICIAN STAFFING AND EMERGENCY PROCEDURES:** As a Specialty Hospital we believe that every patient should be cared for in a location which can best meet their clinical needs. That is why Insight Surgical Hospital has developed a facility with a special focus on surgical services. On rare occasions a patient’s condition might change in an unexpected manner which is outside the scope of services we provide. During these occasions you may need to be transferred to another health care provider which can meet those unexpected needs. You should be aware that this facility: **DOES NOT have a physician available on the premises 24 Hours a day 7 days a week.** In the event of an emergency medical condition and no physician is present at the hospital, the medical needs of the patient will be met utilizing the following procedure: ● On presentation, each patient will be taken to a suitable care area with the capability of a Registered Nurse to provide Advanced Cardiac Life Support and treat the immediate needs of the patient following approved protocols.

 ● The nurse will assess the patient and provide immediate care as needed.

 ● The nurse will notify an available in house physician, if not in-house, will contact the attending physician.

 ● Orders received will be followed.

 ● All care will be documented in the medical record.

 ● Care will be provided within the scope of the facility

 ● The physician will determine if continued care can be provided at the facility.

 ● If not, prepare for transport via the system which would best meet the patients emergency needs.

 ● Follow hospital transfer policy.

 ● In the event of immediate life threatening situations, immediate resuscitative measures will be taken and appropriate emergency response services activated to meet the patients needs both internal to the facility and as appropriate external to the facility.

**24) HOSPITAL POLICY STATEMENT:** If you don’t have someone you want to appoint to make decisions when you’re not able to, you can sign a living will to direct that life-prolonging treatment not to be used in certain situations. We also have information that tells you more about all the forms mentioned above and how to fill them out. This health group supports a patient’s right to participate in health care decision making. Through education and inquiry about advance directives, this Hospital encourages patients to communicate their health care preferences and values to others. We have formal policies to ensure that your wishes about treatment will be followed and we do not condition the provision of care or otherwise discriminate against anyone based on whether or not you have executed an advance directive.

My signature acknowledges that I have received a copy of the Hospital’s policy and my rights as outlined by the “Patient-Self Determination Act”: Indicate Status:

 \_\_\_\_ I have not previously executed an Advanced Medical Directive and do not choose to execute one at this time. \_\_\_\_ I have not previously executed an Advanced Medical Directive. I choose to execute one at this time.

 \_\_\_\_ I have previously executed an Advanced Medical Directive and I have provided a copy.

 \_\_\_\_ I choose to waive my current Advanced Medical Directive for this elective admission

 \_\_\_\_ I have summarized my Advanced Medical Directive as follow: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Organ Donation: Are you an Organ Donor? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

**25) ADVANCED DIRECTIVES:** This explains your right to participate in healthcare decisions and how you can plan what should be done when you can’t speak for yourself. A federal law requires us to give you this information. The law is intended to increase your control over medical treatment decisions. **Who decides about my treatment?** Your doctors will give you information and advice about treatment. You have the right to choose. You can say “Yes” to treatments you want. You can say “No” to any treatment that you don’t want, even if the treatment might keep you alive longer. **How do I know what I want?** Your doctor must discuss your medication condition, treatment options and pain management alternatives that may be available for you. Many treatments have “side effects.” Your doctor must offer you information about problems that any medical treatment is likely to cause you. Often, more than one treatment might help you and people have different ideas about which is best. Your doctor can tell you which treatments are available to you, but your doctor can’t choose for you. That choice is yours to make and depends on what is important to you.

**What if I become too sick to decide?** If you can’t make treatment decisions, your doctor will ask your closest relative or friend to help decide what is best for you. Most of the time, that works. But sometimes everyone doesn’t agree about what to do. That’s why it’s helpful if you say in advance what you want to happen when you can’t speak for yourself. There are several kinds of “advanced directives” that you can use to say what you want and who you want your doctors to listen to in this event.

**Who can fill out this form?** You can if you are 18 years or older and are capable of making your own medical decisions. You do not need a lawyer. **Who can I name to make medical treatment decisions when I’m unable to do so?** You can choose an adult relative or any other person you trust as your “agent” to speak for you when you’re too sick to make your own decision.

**How does this person know what I would want?** Once you choose someone, talk to that person about what you want. You can also write down in the “Power of Attorney for Health Care” when you would or wouldn’t want medical treatment. Talk to your doctor about what you want and give your doctor a copy of the form. Give another copy to the person named as your agent, and bring a copy with you when you go into a hospital or other treatment facility.

 Sometimes treatment decisions are hard to make and it truly helps your family and your doctors if they know what you want. The “Power of Attorney” also gives them legal protection when they follow your wishes.

**What if I don’t have anybody to make decisions for me?** You can still put in writing your wishes about treatment. Documents that do this are often called “living wills” because they take effect while you are still alive but have become unable to speak for yourself.

 When you sign this form it tells your doctors that you don’t want any treatment that would prolong your dying. All life sustaining treatment would be stopped if you were terminally ill and your death was expected soon, or if you were permanently unconscious. You would continue to receive treatment to keep you comfortable, however.

 If you have a living will, the doctors must follow your wishes about limiting treatment or turn your care over to another doctor who will. Your doctors are also legally protected when they follow your wishes.

 If the living will does not suit you, you can fill out a non-statutory living will to state when you would or wouldn’t want to be treated. There are many different living wills forms available or you can just write down your wishes on a piece of paper. Your doctors and family can use what you write in deciding your treatment.

**Can’t I just tell somebody what I want?** You can talk with your doctors and ask them to write down what you’ve said in your medical chart. And you can talk with your family. But people will be clearer about your treatment wishes if you write them down. And your wishes are more likely to be followed if you write them down.

**What if I change my mind?** You can change or revoke any of these documents at any time as long as you can communicate your wishes. **Will I still be treated if I don’t fill out these forms?** Absolutely. You don’t have to fill out any forms if you don’t want to. You will still get medical treatment. We just want you to know that if you become too sick to make decisions, someone else will have to make them for you. Remember that: A Power of Attorney for Health Care lets you name someone to make treatment decisions for you when you are not able to speak for yourself, not just to life-sustaining treatment. Besides appointing an agent, you can also use the form to say when you would and wouldn’t want particular kinds of treatment.

I understand and accept the terms of this agreement as well as the Patient Consent, Notices and Conditions of Treatment listed on the separate form provided and certify that I am the patient or I am duly authorized by the patient or by law to execute the above agreement on their behalf.

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Patient Name Signature DOB Date Time

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Patient’s Guardian or Representative Relationship to Patient Witness