FERRIS STATE UNIVERSITY

BIRKAM HEALTH CENTER

CONSENT TO TREAT

Thank you for choosing Birkam Health Center. Please review the form below so we can provide the optimal care for you, bill appropriately, and share your information securely.

CONSENT FOR TREATMENT

By signing this form, I _____ consent to and authorize the provider(s) at Birkam Health Center to treat me or my dependent. I understand this could include lab tests, immunizations, medication prescription and/or administration, education, minor procedures/surgeries, telemedicine, or behavioral health interventions. I understand that my provider is available to explain the treatment and I have the right to refuse treatment. I understand that this consent will be valid and remain in effect for one year from the date of signature.

CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Birkam Health Center to release any information acquired during my examination and treatment to any authorized agent for the purposes of healthcare, treatment, and payment. I authorize the release of medical and/or behavioral health information to my insurers as necessary for determination and payment of benefits.

HEALTH INFORMATION EXCHANGES

Birkam Health Center endorses, supports, and participates in electronic Health Information Exchange (HIE) to improve the quality of your health and healthcare experience. HIE provides us with a way to share patients' clinical information electronically securely and efficiently with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to share information and provide you with better care more effectively. The HIE also enables emergency medical personnel and other providers who participate in an HIE including but not limited to EPIC CARE EVERYWHERE and who are treating you, to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures.
I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

NOTIFICATION OF PRIVACY PRACTICES ACKNOWLEDGEMENT:

Birkam Health Center complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I hereby acknowledge that a copy of the HIPAA privacy notice was made available to me.

CONSENT TO BILL, ASSIGNMENT OF BENEFITS, AND PAYMENT

I authorize Birkam Health Center to file a claim with my insurance carrier for services rendered. I authorize payment of benefits directly to Birkam Health Center, for services provided to my dependent or me. I understand that I am responsible for any part of the charges that are not covered/paid by my insurance, and I will be billed directly for those services on my student account at the insurance rate. This is true except in cases where Michigan or federal law, or an agreement between my insurance company and Birkam Health Center does not allow.
** If you are uninsured, please note that your account is your responsibility. No patient will be denied services due to his/her inability to pay. Discounts for essential services are offered.

Important Patient Information

1) I agree that Birkam Health Center may do a HIV test on me, if any of its employees sustain a needle stick or other exposure to my blood or body fluids.
2) I understand that I may receive care through telemedicine services. The limitations of a telemedicine visit include the possibility of not being able to pick up conditions found during a complete physical exam in the clinic. I also understand that many insurances do not cover telemedicine benefit, it is up to me to ensure that my insurance does cover this service and if it does not, I will be responsible for covering the costs on my student account.
3) I may receive services from medical students (Nursing students and Nurse Practitioner students) chosen and overseen by the medical staff at Birkam Health Center. I consent to being treated by a student with direct oversight by the providers at Birkam Health Center. My health care records may be used and read by students for teaching purposes.

_____

Sign: Patient Signature (if patient over 18 years of age)

_____ _____

Sign: Parent/ Guardian (Patient under 18) Print: Parent/ Guardian

_____

Date of Signature