200 North Park Street
Kalamazoo, MI 49007-3731
Phone: 269.382.2500 / Fax: 269.373.0123
www.wmcc.org

ADMINISTRATIVE

PERMISSION TO PROVIDE SERVICES

I, the named patient, my minor child or other person I am legally responsible for, consent to have West Michigan Cancer Center & Institute for Blood Disorders (WMCC) provide health care services according to WMCC's scope of services, policies and procedures and approval of my physician.

I consent to abide by WMCC's specific policies and procedures relating to health care provided.

PERMISSION FOR DISCLOSURE AND USE OF INFORMATION

I authorize WMCC or the designated billing agent to disclose all or any part of the patient's medical record to any agency which is or may be liable under contract for all or part of the bill (including, but not limited to hospital or medical service companies, physician billing services, health care service plans, workers compensation or disability carriers, welfare funds and employers), or physicians, agencies, companies or facilities involved with continuity of care.

PERMISSION TO PAY HEALTH CARE BENEFITS TO WMCC OR DESIGNATED HOSPITAL BILLING AGENT

I authorize the release of any information needed for payment to a third party payor, intermediary, or carrier. I request that payment be made to the provider of services or designated hospital billing agent.

PATIENT RESPONSIBILITY FOR PAYMENT OF SERVICES

I hereby assign payment to WMCC of any medical benefits payable to me under the conditions of my policy for services given. I understand that I am responsible for any health insurance deductible and co-insurance, or for the entire bill or balance of the bill as determined by WMCC, if the submitted claims or any part of them are denied for payment.

I understand that WMCC (or designated billing agent) will present claims for the payment of my health care services to my insurance company(ies) or through contracts that may be available to WMCC.

I understand that WMCC's (or designated billing agent's) failure to request immediate payment shall not release me or my estate from the obligation to pay.

I understand that this consent may be revoked by me at any time.

I certify that I understand this document, have received a copy hereof, and accept its terms. I also certify that all information given by me is correct. I have had the opportunity to ask any questions, and they have been answered to my satisfaction.

Patient Name Printed: ____

Patient or Guardian / Activated DPOA Signature: ____ Date: ________________

Name and relationship if not the patient: ____

Staff Witness Signature: ____ Date: ________________

WMCC PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

1. Be given information about your rights and responsibilities for receiving services.
2. Receive a timely appointment regarding your request for services.
3. Be given information of WMCC's policies and procedures and charges for services, including your eligibility for third party reimbursement.
4. Be given information concerning available services, including after-hours and emergency services.
5. Choose your health care providers.
6. Be given professional quality services without discrimination against your race, creed, color, religion, sex, national origin, sexual preference, handicap, age or ability to pay.
7. Be treated with courtesy, respect, consideration, and dignity by all who provide services.
8. Be free from physical and mental abuse and/or neglect.
9. Be given proper identification by name and title of everyone who provides services.
10. Be given the necessary information so you will be able to give informed consent for treatment prior to any treatment.
11. Be given complete and current information concerning your diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose, in terms and language you can reasonably expect to understand.
12. A plan of care that will be developed to meet your health care needs.
13. Participate in the development of your health care plan and ethical issues.
14. Be given an assessment and update of the health care plan as necessary.
15. Be given data privacy and confidentiality.
16. Review or allow your designated representative to review your medical records within 24 hours of your written request and receive copies of your records for a reasonable fee.
17. Refuse to release information contained in your health record within confines of the law.
18. Be given information regarding anticipated transfer of your care to another facility and/or termination of services to them.
19. Voice grievances with and/or suggest changes in services/staff without being threatened, restrained or discriminated against.
20. Refuse treatment within the confines of the law.
21. Refuse to participate in experimental research
22. Be given information concerning the consequences of refusing treatment or not complying with therapy.

AS A WEST MICHIGAN CANCER CENTER PATIENT, YOU HAVE THE RESPONSIBILITY TO:

1. Give accurate and complete health information concerning past illnesses, hospitalization, medications, allergies and other pertinent items.
2. Assist in maintaining a safe environment.
3. Inform WMCC when you are not able to keep an appointment.
4. Participate in the development and update of your treatment plan.
5. Adhere to the developed plan.
6. Request further information concerning anything you do not understand.
7. Share information regarding concerns and problems with WMCC staff members.
8. **Review and understand the rights and responsibilities described above.**