WMCC # _____

West Michigan Cancer Center
& INSTITUTE FOR BLOOD DISORDERS
A Borgess Bronson Collaboration

200 North Park Street
Kalamazoo, MI 49007-3731
Phone: 269.382.2500 / Fax: 269.373.7478
www.wmcc.org

ADMINISTRATIVE

GENERAL CONSENT

I, the undersigned Patient, my minor child or other person I am legally responsible for, agree to abide by WMCC's policies and procedures, as well as the general provisions included in this General Consent, relating to health care services provided to me by WMCC.

PERMISSION TO PROVIDE SERVICES
I 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 the approval of my physician.

PERMISSION FOR USE AND DISCLOSURE OF INFORMATION
I understand and agree that WMCC may release my medical information for purposes of treatment, payment, and health care operations, and as required by law. Individuals and entities to which my medical information may be released include, without limitation, physicians and other providers involved in my care and treatment, third party payors, health plans and administrators, government agencies, hospital or medical service companies, physician billing services, health care service plans, worker's compensation or disability carriers, welfare funds, employers, and agencies, companies, or facilities involved in continuity of care.

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES
I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my health information. By signing below, I acknowledge that I have received, read, and understood the Notice of Privacy Practices provided to me by WMCC which contain a description of the uses and disclosures of my health information which may be made by WMCC. I have had the opportunity to ask questions regarding my rights and any questions I had have been answered to my satisfaction. I understand my rights with respect to my health information as described in the Notice of Privacy Practices.

AUTHORIZATION FOR PAYMENT AND ASSIGNMENT OF BENEFITS
WMCC is authorized to act on my behalf in the requesting and collection of benefits and payment from any third party responsible for payment of my medical care and has the right to take any lawful action to seek payment of my WMCC charges. I hereby assign WMCC all medical benefits payable to me under the conditions of my policy for health care services provided by WMCC.

PATIENT RESPONSIBILITY FOR PAYMENT OF SERVICES
I understand and agree 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 in whole or in part are denied for payment. I understand that WMCC's (or its designated billing agent's) failure to request immediate payment shall not release me or my estate from the obligation to pay. I agree that if my account is not paid when due, and WMCC incurs costs collecting (e.g. legal or collection agency fees), I will be responsible to reimburse WMCC for all costs, charges, and fees associated with collecting the amount due.

By signing below, I certify that I understand the information provided to me in this General Consent, have received a copy, and accept and agree to its terms. I have had the opportunity to ask questions, and any questions I had have been answered to my satisfaction. I also certify that all the information given by me is correct.

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 RIGHT 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 the 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 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.**