Cherry Health
Comprehensive. Quality. Healthcare.

Patient Name (Please Print)	Date of Birth

Consents and Acknowledgements

General Treatment

I understand that:

- Cherry Health (CH) offers care (medical, behavioral, substance use disorder, dental and vision care) in an integrated (combined) setting.
- Some health information is specially protected. I must give consent to share this information in some cases. This information includes HIV/AIDS status, sexually transmitted infections (STIs), tuberculosis (TB), hepatitis B, genetic information, and behavioral health and substance use disorder information.
- My health record is electronic and includes all the services I receive at CH and all specially protected health information.
- My treatment may be photographed, or video/audio recorded for medical or educational purposes. Images that identify me will only be released if I give consent or if needed for my treatment.
- My provider will treat only what he/she is capable of treating. I may ask for another opinion from a supervising provider.
- I may ask to be seen by a specific provider.
- CH takes part in teaching programs. A student may examine me with my verbal consent and under direct supervision of their CH supervisor.
- I may choose not to receive any services recommended by my provider, unless it is required by a court order.
- CH may inform me if I am eligible to take part in research studies. My decision to take part in research will not affect my care.
- CH has put in place protections to keep the privacy and accuracy of all my medical information including alcohol and substance use disorder treatment. These protections follow all state and federal privacy laws including the Health Insurance Portability and Accountability Act (HIPAA) and the Michigan Mental Health Code.
- CH offers secure online access to my electronic health records through the patient portal. This access is voluntary.
- I may allow another person access to my patient portal and I understand that this will allow the authorized individual access to my entire electronic health record.
- If CH discharges me, CH may contact me for a follow-up survey about how satisfied I am with the care I received.
- CH may tell my family or friends about my location and condition if there is an emergency or disaster.
- I can ask CH to limit the use of my Protected Health Information (PHI).

I consent to:

- CH staff examining and caring for me.
- CH ordering tests to help care for me. These tests may include a test for HIV. I may decline or postpone this test without affecting my status as a patient.

The Electronic Health Record and My Protected Health Information (PHI)

I consent to:

- CH working with other health care providers to coordinate, manage and give health care to me.
- CH using and sharing my PHI and specially protected health information through written, verbal or electronic communication for the purposes of:
    - prescriptions with my preferred pharmacy
    - referrals to specialists
    - coordination of care
    - checking current insurance status
    - pre-admission or continued length of stay certification
    - other purposes needed to improve quality of health care I receive; for example, avoiding unnecessary or repeat testing
- CH using and sharing my PHI and specially protected health information for purposes of payment to:
    - insurance companies
    - managed care organizations
    - my employer (if I am injured at work)
    - state and federal government programs like Medicaid and Medicare
    - Workers' Compensation programs

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The Health Care Exchange and My Protected Health Information

I understand that:

- CH participates in a health care information exchange (HIE) through the Great Lakes Health Connect (GLHC). GLHC follows all state and federal privacy laws to maintain the security of my protected health information.
- I understand that more information about HIE and GLHC is available to me at the location(s) I receive my health care services and on the CH website.

I consent to:

- Participate in HIE. I understand that my entire health record including specially protected information is included (see second bullet in "I understand that" section for information on specially protected information).

Assignment of Benefits and Financial Responsibility

I understand that:

- If I do not assign benefits, I will be billed the full cost of all services including behavioral health and substance use disorder treatment.
- If my insurance does not pay for all or part of my services, I may be responsible to pay for those services.
- I must follow CH's financial policies in order to continue my care at CH.

I give permission for:

- My insurance to pay my benefits directly to CH.

Notice of Privacy Practice Acknowledgement

I understand that:

- Following HIPAA, CH will use and share my PHI for:
  - treatment of my health condition(s) and providing continuous (ongoing) care
  - payment for my health services
  - Research
  - routine processes including quality improvement, accreditation, educational purposes or other disclosures as required by law
- The Notice of Privacy Practices is available to me at the location(s) I receive my health care services and on the CH website.

Communicating with Me

I understand that:

- CH will leave messages at the phone number I give for appointment reminders, prescription refills, referrals and/or testing.
- CH may also send me text messages or emails using the contact information that I give.

I consent to:

- CH, including CH's business partners (e.g. reminder calls), contacting me by telephone at any number given by me or that is in my PHI. This includes cell phone numbers, which may result in charges to me.

I give the person(s) listed below access to my entire PHI. I also authorize CH to talk about my entire PHI to the person(s) listed below.

Name_____Relationship_____Phone Number_____

Name_____Relationship_____Phone Number_____

I give permission to the individual listed below to bring my children to their health care appointments and pick up medication from the pharmacy.

Name_____Relationship_____Phone Number_____

I agree to all of the above and understand this consent will remain in effect for one year from the date signed or until I notify CH of any changes in writing.

Patient/Parent/Legal Guardian Signature **Date**

Witness Signature **Date**

If a signature is not obtained, staff must document the good faith efforts to obtain the acknowledgement and the reason why it was not obtained. Reason:

Staff signature_____ Date_____

This form is compliant with HIPAA privacy regulations, 45 CFR Parts 160 and 164 as modified August 14, 2002, 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq and PA 129 of 2014, MCL 330.1141a.