MUNSON HEALTHCARE

TEMPORARY DELEGATION OF PARENTAL RIGHTS AND CONSENT TO MEDICAL TREATMENT OF A MINOR OR DEPENDENT ADULT

Anytime you are going to be separated from your children or those under your care, be sure to leave written permission for emergency treatment on file with Munson Healthcare. By law, hospital emergency personnel cannot provide treatment in the event he or she becomes ill or injured, except in life or death situations, without parental/guardian authorization. Care could be needlessly delayed while the hospital attempts to contact you. With the proper consent on file, you ensure immediate care, should it be necessary in your absence.

Kalkaska Memorial Health Center
Mackinac Straits Health System
Munson Healthcare Cadillac Hospital
Munson Healthcare Charlevoix Hospital
Munson Healthcare Grayling Hospital
Munson Healthcare Manistee Hospital
Munson Healthcare Otsego Memorial Hospital
Munson Medical Center
Munson Urgent Care
Paul Oliver Memorial Hospital

Other: ______________________

Instructions:

1. **Complete both pages of this form and deliver to any Munson Healthcare facility so it can be scanned into the electronic health record.**
2. **Keep a copy and give a copy to the adult(s) you have designated, explain its use and instruct them to bring this form with them if they are seeking treatment for the minor(s) or dependent adult(s) under their care.**

TELEPHONE NUMBER AND ADDRESS WHERE PARENT OR GUARDIAN CAN BE REACHED:

Phone (______) ______________________ Phone (______) ______________________

Address: ____

HMO/INSURANCE/PRIMARY CARE PROVIDER INFORMATION:

Private physician: ______________________ Phone: (______) ______________________

Insurance: ____
Company Policy Number

MINOR PATIENT OR DEPENDENT ADULT MEDICAL INFORMATION: (list each child/dependant adult)

Name(s) of Minor or Dependent Adult	Known Allergies/Drug Sensitivities	Known Medical Conditions	Last Tetanus Immunization

PATIENT ID LABEL

MUNSON HEALTHCARE

TEMPORARY DELEGATION OF PARENTAL RIGHTS AND CONSENT TO MEDICAL TREATMENT OF A MINOR OR DEPENDENT ADULT

PERMISSION FOR TREATMENT

Name(s) of child/children/dependent adult(s): (please type or print legibly)

Last	First	Middle	Birthdate
Last	First	Middle	Birthdate
Last	First	Middle	Birthdate
Last	First	Middle	Birthdate

Parent/legal guardian giving consent (PRINT) ______________________

Last First Middle

I am the parent or legal guardian of the above-named minor child/children/dependent adult(s). I appoint the following individuals Limited Power of Attorney to act for me and to give the required consents and authorization for the delivery of medical care, diagnoses and treatment, including surgical intervention, if necessary, on behalf of my minor child/children or dependent adult(s):

NAME OF RESPONSIBLE ADULT	PHONE NUMBER	NAME OF RESPONSIBLE ADULT	PHONE NUMBER
NAME OF RESPONSIBLE ADULT	PHONE NUMBER	NAME OF RESPONSIBLE ADULT	PHONE NUMBER

I authorize the above permission for a period of time during my absence from _______________ to _________________ (not to exceed 6 months) and to do all other necessary things as I might or could do if personally present. I understand this delegation includes receiving health information about the minor necessary to make health decisions.

This limited Power of Attorney is given pursuant to the provisions of PA 386 of 1998, Sec 700.5103 of the Estates and Protected Individuals Code and said Power of Attorney is not to exceed six months(or longer, for up to 30 days following return from overseas deployment of active military personnel). This form does not delegate power to consent to marriage or adoption.

INSTRUCTIONS: At least one parent or legal guardian must sign this form AND obtain signatures for either options 1 or 2

PARENT OR GUARDIAN DATE TIME

PARENT OR GUARDIAN DATE TIME

Option 1: Two witness signatures are required. The witnesses should NOT be employed by Munson Healthcare (per policy 043.002.), related by blood or marriage, or listed above as being delegated consent.

WITNESS DATE

WITNESS DATE

OR Option 2: On this day, before me, the undersigned Notary Public, the parent(s) or guardian(s) herein named personally appeared and freely executed this document. He/she/they are personally known to me or has/have provided satisfactory evidence of their identity.

Notary Public

SIGNATURE DATE

PATIENT ID LABEL

MUNSON HEALTHCARE
OMH Medical Group
A Service of Otsego Memorial Hospital

CONSENTS

Patient Name: ___________________________ Date of Birth: ________________

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

I HEREBY AUTHORIZE MUNSON HEALTHCARE OMH MEDICAL GROUP STAFF AND ITS REPRESENTATIVES TO RENDER ROUTINE HEALTH CARE TO MYSELF OR MY CHILD. I UNDERSTAND THAT ROUTINE HEALTH CARE IS CONFIDENTIAL AND MAY INVOLVE PROVIDER OFFICE VISITS WHICH INCLUDE HISTORY TAKING, EXAMINATIONS, AND ADMINISTRATION OF MEDICATIONS, DIAGNOSTICS SUCH AS LABORATORY OR RADIOLOGY SERVICES AND/OR MINOR PROCEDURES. I CONSENT TO THE TAKING OF PHOTOGRAPHS OF APPROPRIATE PARTS OF THE BODY DURING THE COURSE OF MY CARE OR THE CARE OF MY CHILD FOR THE INCLUSION IN THE MEDICAL RECORD OR FOR EDUCATIONAL PURPOSES.

I UNDERSTAND THAT MUNSON HEALTHCARE OMH MEDICAL GROUP HAS A TEAM BASED APPROACH TO MEDICINE AND A PROVIDER MAY REFER ME OR MY CHILD TO WORK WITH OTHER TEAM MEMBERS WITHIN MUNSON HEALTHCARE OMH MEDICAL GROUP, MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL OR A COMMUNITY SERVICE PROVIDER SUCH AS A CARE MANAGER, COMMUNITY HEALTH WORKER, PHARMACIST OR PHARMACY SPECIALIST, OR SPECIALTY CARE SERVICES. ALL OF THESE SERVICES WILL BE BILLED THROUGH MY INSURANCE AND MAY OR MAY NOT HAVE COST SHARE DEPENDING ON THE PLAN. CARE MANAGEMENT MAY BE SUPPLIED BY OTHER PROVIDERS AND MUNSON HEALTHCARE OMH WILL WORK WITH OTHER HEALTH CARE PROVIDERS TO MAKE SURE ONLY ONE PROVIDER IS BILLING FOR CARE MANAGEMENT AT ANY POINT IN TIME. AS WITH ANY SERVICE I MAY DECLINE AT ANY TIME.

IN CONSIDERATION OF THE SERVICES RENDERED, I HEREBY EXPRESSLY AGREE TO PAY IN FULL, ANY AND ALL CHARGES FOR PROVIDER SERVICES RENDERED AND MATERIALS FURNISHED TO OR FOR THE PATIENT BY THE MUNSON HEALTHCARE OMH MEDICAL GROUP AND MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL. I HEREBY ASSIGN PAYMENT DIRECTLY TO THE ABOVE HOSPITAL OF AUTHORIZED BENEFITS TO BE MADE IN MY BEHALF, NOT TO EXCEED THE BALANCE DUE OF THE PROVIDER'S REGULAR CHARGES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE HOSPITAL FOR CHARGES NOT COVERED BY THIS AUTHORIZATION UNDER THE PROVISIONS OF THE FEDERAL TRUTH IN LENDING LAW 7196.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

- I UNDERSTAND THAT AS PART OF MY HEALTHCARE, MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL USES HEALTH INFORMATION AND MEDICAL RECORDS DESCRIBING ALL ASPECTS OF MY CARE. IT IS USED FOR:
  - PLANNING MY CARE AND TREATMENT.
  - COMMUNICATING WITH HEALTH PROFESSIONALS INVOLVED IN MY CARE.
  - A SOURCE OF INFORMATION FOR BILLING.
  - A MEANS BY WHICH ANY PAYER CAN VERIFY THAT SERVICES BILLED WERE PROVIDED, AND ASSIST WITH OUR PROVIDERS BEING PAID FOR SERVICES AND CARE PROVIDED TO ME; AND A TOOL USED FOR ROUTINE HEALTHCARE OPERATIONS TO MEASURE THE QUALITY OF MY CARE.
- I ACKNOWLEDGE THAT (1) IF I AM A FIRST TIME PATIENT, I WAS OFFERED AND HAVE RECEIVED A COPY OF MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL'S NOTICE OF PRIVACY PRACTICES; OR (2) IF I AM NOT A NEW PATIENT TO MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL, I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES AT A PREVIOUS VISIT.
- I UNDERSTAND THAT MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL RESERVES THE RIGHT TO CHANGE THIS NOTICE AND WILL POST A COPY OF ANY REVISED NOTICE IN ITS WAITING ROOMS AND EXAMINATION ROOMS AND WILL PROVIDE ME WITH A COPY UPON MY REQUEST.
- I UNDERSTAND THAT I HAVE THE RIGHT TO OBJECT TO THE USE OF MY HEALTH INFORMATION FOR DIRECTORY PURPOSES AND TO REQUEST RESTRICTIONS AS TO HOW MY HEALTH INFORMATION IS USED OR SHARED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.
- I UNDERSTAND THAT MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS REQUESTED.
- THE NOTICE OF PRIVACY PRACTICES IS POSTED IN A CLEAR AND PROMINENT LOCATION WHERE I AM ABLE TO READ THE NOTICE.
- I KNOW THAT I CAN ASK FOR A COPY OF THE NOTICE OF PRIVACY PRACTICES TO TAKE WITH ME.
- I WAS ABLE TO VIEW THE NOTICE OF PRIVACY PRACTICES ON THE FIRST DAY I RECEIVED HEALTH CARE SERVICES.
- I AM ABLE TO VIEW THE NOTICE ELECTRONICALLY AT THE MUNSON HEALTHCARE OMH WEBSITE AND MUNSON HEALTHCARE OMH PATIENT PORTAL.
- IF I CAME IN FOR HEALTH CARE SERVICES IN AN EMERGENCY TREATMENT SITUATION, I WAS ABLE TO VIEW THE NOTICE AS SOON AS REASONABLY PRACTICABLE AFTER THE EMERGENCY TREATMENT.

______________________________________ ______________________ ____

PATIENT/LEGAL REPRESENTATIVE SIGNATURE DATE RELATIONSHIP TO PATIENT

MUNSON HEALTHCARE
Otsego Memorial Hospital

PATIENT PRIVACY AND PHONE MESSAGES

Patient Name: ____ **Date of Birth** _________________________
(Please Print)

PEDIATRIC PATIENTS & PATIENTS WITH A LEGAL GUARDIAN ONLY:

Mother (or Legal Designee): ____
(Please Print)

Father (or Legal Designee): ____
(Please Print)

HIPAA Privacy allows Munson Healthcare (MHC) and business associates to disclose the minimum necessary protected health information (PHI) to family members or friends who are responsible for or appear to be involved in your medical care or your health care bills. MHC may also notify your family or friends of your location and condition in the event of an emergency or disaster.

HIPAA and MHC policy allows us to leave messages at the phone number you provide regarding appointment reminders, prescription refills, referrals or testing. **You may agree to these uses of your PHI or you may ask us to limit our use of your protected health information.** For example, you may request we use another phone number or an email, or another address.

1. Do we (MHC and business associates) have your permission to contact you by the phone number(s) you have provided to us? ☐ YES ☐ NO

SHARE: (List the full name, relationship and phone numbers of the family members and/or friends who are or may be involved with your care that Munson Otsego Memorial Hospital may share your health information with)

Name	Relationship	Phone

My signature below indicates I have completed the above sections to the best of my ability. I understand that the above permissions will stay in effect unless I notify MHC of changes.

____
Signature of Patient, Parent, or Legal Guardian

Relationship to Patient:
Patient ☐ Parent ☐ Guardian ☐
Other ☐ Describe if Other: ____________________

____
Date

MUNSON HEALTHCARE
Otsego Memorial Hospital

REGISTRATION FORM

Pediatric Patients / Patients with a Guardian

Patient:

Date of Birth: ____________________ Gender: ☐ Male ☐ Female

Last Name: ____ First Name: ______________________________ M.I.____________

Street Address: ________________________________ City: __________________________St:_________Zip:________________

Primary Care Provider: ______________________________________ Pharmacy: ____

Other Care Team Providers: ____

Patient care decisions are made without regard to race, religion, age, sex, color, national origin, disability and in full compliance with all Federal State Laws. **Please select one Ethnicity & One Race:**

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino Preferred Language: _____________________

Race: ☐ Caucasian ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Black or African American
☐ American Indian or Alaska Native ☐ Multiple ☐ Other

Mother:

Last Name: ____ First Name: _______________________________ M.I.____________

Phone #: ____E-Mail Address: ____

Street Address: _______________________________________ City: __________________________St:_________Zip:______________

PO Box #: _____________ City: ____St:______________________Zip:___________________

Date of Birth__________________________ SS#____ Marital Status_______________________

Employer Name & Address: ____

Insurance: ____ ☐ Primary ☐ Secondary ***Insurance Cards are Required at Check In***

Father:

Last Name: ____ First Name: _______________________________ M.I.____________

Phone #: ____E-Mail Address: ____

Street Address: _______________________________________ City: __________________________St:_________Zip:______________

PO Box #: _____________ City: ____St:______________________Zip:___________________

Date of Birth__________________________ SS#____ Marital Status_______________________

Employer Name & Address: ____

Insurance: ____ ☐ Primary ☐ Secondary ***Insurance Cards are Required at Check In***

With whom does the patient reside: ☐ Mother ☐ Father ☐ Joint Custody ☐ Other (identify)______________________

Who has legal custody of the child: ☐ Mother ☐ Father ☐ Joint Custody ☐ Other (identify)______________________

Please note that Munson OMH will assume that a biological or adoptive mother and father have full legal ability to obtain information about their child and to seek medical treatment about their child unless a court order is presented and on file with Munson OMH.

____ ____
Signature of Person Completing Form **Relationship to Patient**

____ ____
Printed Name of Person Completing Form **Date**