MedEQUIP
Agreement and Consent

University of Michigan Hospitals and Health Centers

HOME CARE SERVICES (UMHHC-HCS)
2705 S. Industrial Highway
Ann Arbor, Michigan 48104

MRN: (9-Include leading zeroes) _ _ _ _ _ _ _ _ _
Birthdate:
Patient Last, First Name:

Authorization for Care/Services: I agree to receive care/services including all necessary products, procedures and treatments ordered by my physician. I know that the practice of medicine is not an exact science and outcomes may be different for each patient. I have participated in the planning of my care/services and understand I may refuse any care, treatment, or products at any time.

Release and Receipt of Information: I authorize UMHHC-HCS to release information in any format, via telephone, fax and/or electronic transmittal, contained in my home care record to hospitals, physicians, or other health care providers for the purposes of providing and coordinating my care. I also authorize the release of information to all third party payers, insurance carriers, fiscal intermediaries, and other persons or agencies responsible in whole or in part for paying my home health care expenses. Information may also be shared with licensing/accrediting bodies and internal/external auditors for the purposes of medical, regulatory, and quality review.

Payment/Financial Responsibility: I have been informed of the estimate of charges for which I am responsible based on the expected coverage. I certify that my insurance benefit information provided is correct to the best of my knowledge. I agree to notify UMHHC-HCS promptly of any changes in my insurance coverage. I understand UMHHC-HCS will contact me regarding any known changes in my financial liability.
Medicare Beneficiary: I have been provided with the link to view the Medicare Supplier Standards and understand that a written copy will be furnished upon request. I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me by UMHHC-HCS.

Supplemental policies to Medicare: I request that payment of authorized medical benefits be made on my behalf for any services furnished to me by UMHHC-HCS. I authorize any holder of medical or other information about me to release to the Center of Medicare & Medicaid Services and its agents any information needed to determine benefits or benefits for related services.

Patient Rights and Responsibilities: I have received my Rights and Responsibilities, e.g. right to confidentiality, privacy, respect and security, as stated under Michigan law, and information regarding Advance Directives.

Notice of Privacy Practices: I acknowledge that I have received the University of Michigan Hospitals and Health Centers (UMHHC) Notice of Privacy Practices.

Important Patient Information Acknowledgement: I hereby acknowledge that I have received the University of Michigan Hospitals and Health Centers (UMHHC) Important Patient Information. The important patient information can be found in the Home Care Services Patient Guide provided.

I have read and understand the information on this form before I signed it.

_____ ___/___/_____
Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign): Date (mm/dd/yyyy)

_____
Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)
Relationship: ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ DPOA for HealthCare

University of Michigan Hospitals and Health Centers
HOME CARE SERVICES (UMHHC-HCS)
2705S. Industrial Highway
Ann Arbor, Michigan 48104

MedEQUIP
Important Patient Information

1. **The University of Michigan (UM) is a teaching center.** This means I may receive service from staff and trainees chosen and overseen by the teaching staff. Trainees and teachers may read my health care records for teaching, study and education.

2. Human Immunodeficiency Virus (HIV) is the virus that causes AIDS (Acquired Immune Deficiency Syndrome). **Under Michigan law, an HIV test may be done on a patient if any health care worker or emergency responder comes in contact with a patient's blood or other body fluids under the skin, in an open wound, or through the mucus membranes.** If this type of contact occurs, I know that my blood can be tested without my consent. If a test is done, I know that I will be given the test results and will receive counseling as needed.

3. **I understand that I will be responsible for my co-payments, deductibles or other charges for medical services not covered or paid by insurance or other third party payers,** except as prohibited by any agreement between my insurance company and UM or by state or federal law. I assign all rights and benefits to UM in order to facilitate reimbursement for health care services. I will help UM follow up on payment for these claims.

4. **I have received written information on patient rights and responsibilities**, e.g. right to confidentiality, privacy, respect and security, as stated under Michigan law.

5. An Advance Directive is a document saying what kind of care I would want to receive if I were unable to express my wishes. I have been given information on Advance Directives. I know my care will not be affected if I do not have an Advance Directive.

6. **Patient Education**: When home medical equipment/supplies are provided, I have been trained to safely operate and maintain the equipment/supplies. I understand that unless otherwise specified, all equipment provided to me is owned by UMHHC-HCS and I must return that equipment in reasonable condition when services are discontinued. I will be responsible for equipment requiring replacement due to damage. The replacement cost of the equipment ranges from $500.00 to $12,000.00 depending on type.

7. The University of Michigan Health System (UMHS) uses many ways to communicate with patients. The method we use to communicate with you will depend on the reason(s) for communication. **As a patient, by providing the UMHS with my contact information, I am authorizing communications by different methods (e.g., automated calls, text messaging, patient portal, email, etc.) I understand that I have the option to opt out of (not to participate) with certain methods of communication by informing UMHS staff.**