920001

Children's HOSPITAL & MEDICAL CENTER

Patient Label

Patient Last Name	Patient First Name	MI
Patient DOB	Patient Gender ☐ Male ☐ Female	PCP/Physician
Patient Home Address		Preferred Telephone
Admission Date	Admission Time	

MEDICAL CARE CONSENT AND FINANCIAL RESPONSIBILITY AGREEMENT

In my capacity as the parent/legal guardian/legally authorized representative of the patient named above (or as an adult patient or emancipated minor patient), I agree to the following:

I. **CONSENT FOR TREATMENT**: I hereby consent to medical care for myself or the patient named above (the "Patient") at Children's Hospital & Medical Center ("Children's"), including all examinations, assessments, tests, therapy, and other services and procedures that the physicians, other health care providers, and staff of Children's deem necessary or appropriate. I am aware that the practice of medicine is not an exact science and no guarantees have been made to me regarding medical care.

II. **STATEMENT OF FINANCIAL RESPONSIBILITY**: **I hereby agree that I am financially responsible to Children's for all payment obligations arising out of the medical care, services, and supplies ("Care") provided to the Patient during this episode of care.** I agree to promptly and fully pay all amounts (deductibles, co-pays, co-insurance amounts, or any other amounts required by my and/or the Patient's insurance carriers) which are not otherwise covered by insurance. If I and/or the Patient do not have insurance, or if an insurance carrier declines to pay for any reason, I agree to pay for all charges arising out of the Patient's Care during this episode of care.

III. **PHYSICIAN AND STAFF EMPLOYMENT**: I understand that some physicians and other health care providers at Children's may be independent contractors who are authorized to use Children's facilities to provide Care to their patients. Independent contractors are responsible for their own actions and Children's is not liable for their actions or failure to act.

IV. **ASSIGNMENT OF BENEFITS**: I hereby assign to Children's and to any independent contractors providing Care at Children's facilities all applicable insurance benefits, including any Medicare, Medicaid, TRICARE, or other governmental health insurance benefits. If the Patient is a minor or otherwise incapable of signing this Agreement, I certify that I am a legally authorized representative of the Patient, and that this assignment of benefits also applies to any health insurance held in the Patient's name. I understand and agree that Children's and applicable independent contractors will bill insurance carriers on my and/or the Patient's behalf for all Care provided to the Patient, and I request the payment of all authorized insurance benefits directly to Children's and applicable independent contractors. I authorize the release of any information about me or the Patient that is required in order to submit insurance claims for the Patient's Care. I understand that Care provided by independent contractors may be billed separately. My signature below authorizes Children's and applicable independent contractors to submit claims to obtain benefits for Care without obtaining my signature on each claim.

V. **INSURANCE INFORMATION**: I have disclosed all of my and the Patient's health insurance information, including all primary and secondary insurance. I will promptly inform Children's of any changes in insurance information. It is my responsibility to understand all insurance benefits related to the Patient's Care, including exclusions and those services defined as experimental. I understand that I may request an estimate of the cost of any services.

VI. **NOTIFICATION OF HOSPITAL STAY OR EXTENDED STAY**: I acknowledge it is my responsibility to notify my and/or the Patient's insurance carriers at the time the Patient is admitted to Children's. It is also my responsibility to notify all applicable insurance carriers if the Patient's stay becomes an "extended stay" according to the terms of the insurance benefits.

VII. SELF-PAYMENT: I understand that I may choose not to have Children's bill my and/or the Patient's insurance for a particular health care item or service provided to the Patient, and instead choose to personally pay in full the cost of that health care item or service. I understand that in order to exercise this option, I must notify Children's in a timely manner, complete additional forms, and pay all applicable charges promptly and in full.

VIII. FINANCIAL ASSISTANCE POLICY: I understand that Children's has a financial assistance policy and that I may ask about it at any time if my family needs financial assistance. I understand that there is an application process for financial assistance, and that eligibility is based on family income, family size, and other special circumstances. I understand that I may request a copy of the policy, a plain language summary of the policy, or a financial assistance application at any time.

IX. NOTICE OF PRIVACY PRACTICES: I have received a copy of the Children's Joint Notice of Privacy Practices and I understand that the Patient's medical information may be used and disclosed in accordance with the terms of that Notice of Privacy Practices. I understand that I may direct any questions or concerns to the Privacy Officer at (402) 955-4122.

X. PATIENTS RIGHTS AND RESPONSIBILITIES: I have received a brochure containing information about the Patient's rights and responsibilities.

XI. TRICARE INPATIENTS: I have received and understand a notice entitled "An Important Message from TRICARE."

XII. HIV TESTING: I understand testing for the Human Immunodeficiency Virus ("HIV"), which is the virus responsible for Acquired Immunodeficiency Syndrome ("AIDS"), may be ordered for diagnostic purposes. HIV test results are defined as positive, negative, or indeterminate. A positive result means the Patient's immune system is responding to an HIV infection. A negative result means that the Patient is not infected with HIV or that the Patient's immune system is not yet responding to an HIV infection. An indeterminate result means that the test was unclear and further testing is needed. **I understand I have the right to refuse HIV testing of the Patient, and by initialing here I am exercising my right to refuse: (_____).**

XIII. RESEARCH: Children's is a teaching and research institution. As such, the Patient's records may be used for research with the approval of the Institutional Review Board ("IRB"), as required by and in accordance with federal regulations.

a. RESEARCH ON LEFTOVER SAMPLES: Samples of the Patient's blood, other bodily fluids, and tissues may be collected for testing as part of the Patient's Care. There may be some portions of these samples that are not needed for the Patient's health care tests. These samples could be used by researchers with the approval of the IRB, as required by and in accordance with federal regulations. Research on leftover samples may include the study of genetic material (DNA) or other information in the Patient's samples that may identify risks for specific diseases. Depending on the research, some of the Patient's genetic and health information may be placed into a scientific database for other researchers to use. Access to the Patient's identity and to his/her specific information will be carefully controlled. If research done with the Patient's leftover samples results in discoveries that have commercial value, there are no plans to compensate the Patient. If you do not want the Patient's leftover samples to be used for research, you should write your initials below. A decision to opt out will not affect the Patient's Care. **I do not want the Patient's leftover samples to be used for research_____ (initials).**

b. RESEARCH RECRUITMENT PROGRAM: Based on information in the Patient's medical record, the Patient may qualify to participate in research studies. If you do not want researchers to review the Patient's records as part of their research activities or to contact you or the Patient about studies for which the Patient may be eligible, you should write your initials below. Participation in these studies is completely voluntary, and a decision to opt out will not affect the Patient's Care. **I do not want the Patient's records to be reviewed for research and I do not want the Patient or me to be contacted about research_____(initials).**

c. DURATION: The choices you make about research in this section will not expire and will remain in effect unless and until you or another legally authorized representative of the Patient change them in writing. If you have questions or later wish to change your designation for either leftover sample research or the research recruitment program, you can call the Pediatric Research Office at 402-559-2511.

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XIV. SHADOWING AND OBSERVATION: I understand that some persons involved in the Patient's Care may be medical, nursing, or other health care personnel in training and I consent to their participation. From time to time, other non-Children's staff members may observe the Patient's Care. I understand I have the right to request that any of these individuals not participate in or observe the Patient's Care and that such request will not affect the Patient's ability to receive Care at Children's.

XV. PHOTOGRAPHS AND VIDEOTAPING: I understand that still or motion pictures may be taken of the Patient by Children's and others associated with Children's to document Care, for patient identification, and for related educational purposes. Additionally, I understand that closed circuit television monitoring and recording may be used for general purposes, including Care and security.

XVI. CONTACT BY TELEPHONE: By providing Children's with my landline and/or cell phone number(s), I give my express consent for Children's, its independent contractors, its agents, and its collection agents to contact me at these numbers, or at any number that is later acquired for me, and to leave live or pre-recorded messages or to send text messages regarding any accounts or services. I understand that for greater efficiency, calls may be delivered by an auto-dialer.

I acknowledge that I have read, understand, and agree to the information set forth above, and I certify that if I am not the Patient, I am legally authorized to sign for the Patient.

_____

Signature of Parent with Legal Custody, Legal Guardian, Adult Patient or Emancipated Minor Patient, or Other Legally Authorized Representative of Patient — *Date*

_____

Print Name — *Relationship to Patient*