Conditions of Care

Name of Patient: ________________________________ **Date of Birth:** ______ / ______ /_____
(Please print or type)

CONSENT TO HOSPITAL ADMISSION/CARE and MEDICAL TREATMENT
I hereby consent to and authorize the following:

- Admission and/or treatment for the patient listed above. I further consent and authorize such hospital care encompassing routine laboratory tests including blood testing, radiologic tests including injection of diagnostic material, diagnostic procedures, minor procedures (such as skin biopsy), injections for medical treatment, serial casting, bracing, serial debridement, rehabilitative therapy, burn care and other such medical treatment, including outpatient care, as the Chief of Staff or his assistants or designees shall in their judgment deem necessary.

- The patient's provider may need to photograph and/or record images of the patient for identification and to document a medical condition, help with the diagnosis and/or treatment of a condition and /or to help plan details of surgery.

- In the event of a diagnostic workup, outside consultation and/or an emergency, the patient may be transferred to another hospital or facility for care or treatment.

I agree that this consent will remain in effect until revoked by the patient, parent or legal guardian or upon the patient's 18th birthday or if the patient otherwise becomes eligible to consent on their own behalf.

ASSIGNMENT OF BENEFITS
I agree to provide copies of patient's health insurance card(s) and to provide accurate and timely information to Shriners Hospitals for Children® (SHC) representatives regarding patient insurance coverage and subscriber information, as requested. If there is any change in health insurance coverage, I understand it is my obligation to notify SHC as soon as possible.

Based on the information that I supplied, I agree SHC shall bill patient's insurer(s) for hospital, outpatient and professional services ("Services") provided at SHC. I agree that payment of all insurance benefits shall be made directly to SHC for Services provided to patient now and in the future. If I or policy holder receive any insurance or other payments for Services provided by SHC to patient, I/we agree to promptly send the payments to SHC. I/we give all rights to these payments to SHC. SHC has my/our permission to appeal denials made by insurance providers or government agencies. The patient's health information and insurance information may be used by SHC for treatment of the patient and/or for payment for healthcare services both within and outside SHC; and for hospital operations.

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Shriners Hospitals for Children

Patient Information Label

Shriners Hospitals for Children®

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RELEASE OF INFORMATION

SHC has permission to release patient's medical record to any person or company that performs record keeping or billing services for SHC. Additionally, those who perform billing services for SHC have my permission to request information about medical insurance coverage or medical care benefits from patient's insurance providers (e.g. employer, government agency, etc.). I authorize and request anyone with medical or other information about patient to release that information to SHC, its billing agents, and/or any other payors or insurers as needed to determine benefits payable for Services provided to patient by SHC, now and in the future.

ACCESS TO MEDICATION INFORMATION AND HISTORY

SHC uses an E-prescribing system to access and transmit current prescription information and medication history. I agree that SHC and its providers can access the system to view and use the patient's prior and current prescription medication history for treatment purposes.

SCIENTIFIC AND EDUCATIONAL PURPOSES

I authorize use of patient's health information for scientific purposes, as well as for patient education and clinical presentations for educational purposes. The information used may include the nature of the patient's medical condition, operations or procedures performed, results of diagnostic studies, x-rays, films and photographs. I understand that SHC will use its best efforts to ensure that the patient's identity is not revealed unless specifically authorized.

AUTHORIZATION WHEN PARENT/GUARDIAN IS NOT AVAILABLE

There may be times that I/we will not be present with the named patient or not immediately available. There may be times when it will be necessary for another authorized adult to present the named patient for medical examination and treatment. I/we give permission to SHC and its staff to provide Services to the named patient as they believe necessary in my absence.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received SHC's Notice of Privacy Practices, which describes the ways in which SHC may use and disclose the patient's healthcare information for treatment, payment, healthcare operations and other prescribed and permitted uses and disclosures. I understand that I may contact the Hospital Privacy Officer if I have a question or complaint.

PATIENTS' RIGHTS AND RESPONSIBILITIES

I acknowledge that I have received a copy of SHC's Patients' Rights and Responsibilities brochure. I understand that this brochure contains important information about the rights and responsibilities as a patient at SHC, including a description of SHC's procedures for resolution of any complaints.

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This document will remain in effect for subsequent outpatient Services provided by SHC until revoked in writing by the undersigned, or upon the patient's 18th birthday, at which time a new form will need to be completed. In addition, a new form will be signed for all outpatient surgeries and inpatient admissions. I/we certify that I am/we are the natural or adoptive parents or legal guardian of the patient named above, and that I am/we are legally authorized to consent to the medical care of the patient. I/we agree to notify the hospital if there is any future change in this relationship, and to provide documentation to confirm such relationship, if requested.

I/we understand that I am/we are responsible for payment of any copay, deductible or coinsurance that the applicable insurance requires in connection with Services provided to the patient.

The information supplied to SHC is true, accurate and complete to the best of my/our knowledge.

____________________________________ Date: ____/_____/____ Time: _________
Patient, Parent or Legal Guardian Signature

____
Patient, Parent or Legal Guardian (print name) Relationship (if not signed by the patient)

____________________________________ Date: ____/_____/____ Time: _________
Witness Signature

____
Witness (print name) Witness Address

____________________________________ Date: ____/_____/____ Time: _________
Patient, Parent or Legal Guardian Signature

____
Patient, Parent or Legal Guardian (print name) Relationship (if not signed by the patient)

____________________________________ Date: ____/_____/____ Time: _________
Witness Signature

____
Witness (print name) Witness Address