Logo

CONSENT TO TREAT, RELEASE OF INFORMATION,
AND
FINANCIAL RESPONSIBILITY GUARANTEE

1. CONSENT TO MEDICAL CARE: By my signature or electronic signature below, I warrant that I am the parent or legal guardian of the registered child(ren) named on Page 1 and/or 2 of the Patient Registration Form. I hereby request and authorize the physician and other health care providers of PRACTICE NAME HERE ("the Practice") and their professional staff, to perform any medical diagnostic procedures and medical or surgical care which in their professional judgment is deemed necessary to diagnose and/or treat the conditions(s) that have brought about my seeking medical care services for my child(ren) at the offices of the Practice. I understand that the practice of medicine is not an exact science, and that there are risks and benefits associated with receiving medical treatment. I acknowledge and agree that no guarantees are made to me concerning the results and outcomes of the medical examination and treatment rendered by the physicians and professional staff of the Practice.

2. RELEASE OF MEDICAL RECORD INFORMATION. I hereby authorize the Practice to disclose all or any part or the contents of the medical record of the patients named on this Registration Form to such insurance companies, organizations, or agencies that may be concerned with the payment of medical services rendered to the registered patient(s) consistent with Federal HIPAA regulations. This authorization is given with full knowledge and understanding that such disclosure may contain information which may result in a valid denial of insurance benefits, or which otherwise may not serve the interests of the registered patient(s) or myself.

3. ASSIGNMENT OF INSURANCE BENEFITS: I hereby request and authorize that any and all insurance benefits due and payable for medical services rendered to the patients(s) be paid directly to the Practice.

4. PRIVACY POLICY ACKNOWLEDGMENT: I acknowledge that I have received a copy of the Notice of Privacy Practice for PRACTICE NAME HERE.

5. FINANCIAL AGREEEMENT AND GUARANTEE: I accept full and complete financial responsibility for all medical services rendered to the registered patient(s) and agree to any and all insurance co-payments, deductibles, and co-insurance that may be required under the terms of my medical insurance policies, as well as pay for any medical care that is considered a "non-covered" service under the terms of my medical insurance plan. I further acknowledge, understand and agree, that in the event that I fail to make such payments in accordance with the payment policies of the Practice, or in the event of default of my financial obligation to pay for services rendered, the Practice may terminate the "doctor-patient" relationship with the registered patient(s) in accordance with the Code of Virginia. Furthermore, in the event of my default of my financial obligation, should my account be turned over to an external collection agency for non-payment, I agree to pay any associated collection costs.

I understand that in the event the patient(s) are not covered by a medical insurance plan, I will be required to make a payment deposit of 50% of the estimated cost at the time of visit before any medical care will be rendered. I understand that the payment of the deposit represents only a partial payment of the total fees that may be charged for the medical service to be rendered, and that I will receive a statement for the total charges incurred. I understand that this balance must be paid in full at or before the next visit.

6. HIV / HEPATITIS B OR C TESTING: I acknowledge that I am hereby informed in accordance with Section 21.1 – 45.1 of the Code of Virginia, 1950, as amended, that if the provision of healthcare services to the registered patients(s) exposes any health care provider to the patient's body fluids in a manner which may transmit immunodeficiency virus or HIV or Hepatitis B or C viruses, then the patient shall be deemed to have consented to testing for infection with HIV or Hepatitis B or C viruses, and to the release of such test results to the person(s) exposed, as provided by law.

7. CORRECT INFORMATION: The undersigned certifies that he/she has provided correct information in this Patient Registration Form and understands that any false statements or concealment of material fact may be prosecuted under applicable federal and state laws. The undersigned further certifies that he/she has read, fully understands, and accepts the above information, terms and conditions, and is the patient's parent or legal guardian, duly authorized to execute the above and to accept its terms.

PRACTICE NAME HERE

OFFICE VISITS: are by appointment only. Walk-ins are not given priority over parents who call for appointments per our policy.

LATE POLICY: Patients are asked to arrive 10 minutes before their scheduled appointment time in order to complete the check-in process. Patients arriving more than 20 minutes late will be required to reschedule their appointment to the next available opening consistent with the type of appointment requested. Only acutely ill children will be worked into the provider's schedule later the same day.

CANCELLATION POLICY: As a courtesy to both your provider and other families with sick children, we ask that you cancel any scheduled appointment 24 hours in advance so that others may utilize this time. Failure to attend an appointment without prior cancellation is considered a NO SHOW. NO SHOWS are charged to the patient at $0 per missed visit.

CO-PAYS: must be paid at the time of each visit. This is the policy of your insurance company, which our office is required to comply with. If you fail to pay your co-pay, an self-addressed envelope will be provided to you to mail your payment in within 3 business days. If you fail to make your co-pay and must be billed for it by the office, there will be a $0 processing charge on top of the co-pay.

PRESENT A VALID INSURANCE CARD AT EACH VISIT: If you request that we bill your insurance for your child(ren)'s care, you must present a valid insurance card at each visit. Failure to present a valid card may result in your being required to make a 50% deposit as a self-pay patient for that visit.

CHILDREN UNDER 18 MUST HAVE A PARENT / GUARDIAN PRESENT:
Children under the age of 18 cannot legally consent to their own treatment. Treatment can only be approved by a parent or legal guardian. If you cannot attend their appointment and must send your child(ren) alone, or with an older sibling, grandparent, or nanny, please be aware that they have no legal authority to provide a "consent to treatment" for your child. You must send a SIGNED LETTER OF AUTHORIZATION WITH THEM, or give us written pre-authorization naming the person(s) you approve in advance to consent to treatment on your behalf. If you wish to do this, please request a PRE-AUTHORIZATION FORM from our front desk staff.

PRACTICE NAME HERE
Single Consent to Share Medical Information with Children's IQ Network Providers Treating Me or My Child

INTRODUCTION

As part of our commitment to improve the quality and the coordination of medical care for the children and patients we serve, PRACTICE NAME HERE has elected to participate in the Children's National Health System's IQ Network. This innovative program is the first in the country to attempt to provide real-time coordination of care via an electronic medical record that allows an interface between your or your child's health care provider and one of the country's leading children's hospitals.

This SINGLE CONSENT will allow us to share information, for example, with an ER doctor treating you or your child, or with a specialist to whom you have agreed we are to refer you or your child, so that they are able to quickly access critical information about you or your child from your medical record before beginning treatment. This should dramatically reduce the chance of medical errors, including adverse drug interactions or allergic reactions.

Your and your child's healthcare information is encrypted (encoded) **and can be accessed only by health care providers who are caring for you or your child and have a need to know**.

As PRACTICE NAME HERE is a part of the Children's IQ Network, this written SINGLE CONSENT will allow the sharing of information with any provider within the IQ Network whom you have elected to be involved in your or your child's treatment. You do have the option to opt out of the Children's IQ Network. If you choose to opt out, you will need to sign a separate consent form each and every time you or your child need to be seen by another member of the Children's IQ Network other than those at PRACTICE NAME HERE.

****

PATIENT RIGHTS: I have received a copy of the **Children's IQ Network** (CIQN) Information Sheet. I understand that patient information will still be stored electronically for my provider's records, and that an electronic health summary will be available to other providers through the CIQN. I also understand that I have the right to not share (opt-out) health information with other providers within the CIQN.

PROTECTED DISCLOSURE OF INFORMATION: I understand that Children's National complies with all federal and local regulations including the Health Insurance Portability and Accountability Act; and that this Consent includes my agreement that Children's National can use private health information for my treatment or my child's treatment as defined in the Notice of Privacy Practices. I agree to Children's National use of de-identified health information about me or my child for appropriately reviewed and approved research and quality improvement activities.

Patient Name **Date of Birth**

Signature of Parent/Legal Guardian/Patient 18 yrs of age or older **Date**