Children's Wisconsin

PATIENT LABEL HERE

Outpatient Consent for Treatment

Primary Care, Specialty Care and Ancillary Services

Please read this form. Ask questions if you do not understand before you sign.

Treatment

- I authorize doctors, other health care providers and Children's Hospital and Health System, Inc. ("Children's") employees to evaluate and treat my child.
- Treatment may include physical exams, x-rays, labs, giving or prescribing medicine, ordering or doing tests and procedures, and other care as needed.
- I have the right to talk about options for my child's care. I will have a chance to ask questions.
- Children's may test or properly get rid of any samples or tissues taken from my child's body.
- I understand my child may go home or to another facility before all medical problems are known or treated. I understand that I may need to make appointments for follow-up care.
- Children's is responsible for the actions of its employees. Many doctors and specialists who work at Children's are not employed by Children's. Their employer is responsible for their actions.
- Children's is a teaching organization. Students may be involved in my child's care.

Telehealth Services

If telehealth services are used, I understand the benefits and risks may include the following:

Benefits of telehealth

- Allows access to health care services without the patient and provider being in the same physical location.
- Reduces barriers that may prevent patients and providers from meeting in person.

Risks of telehealth

- Potential delays in evaluation and treatment may occur due to deficiencies or failures of the technology or lack of access to the complete medical record.
- Electronic communications may be compromised, unsecured, or accessed by others. You are responsible for security of your technology (e.g., computer, cell phone and internet connection).
- If you are not in a private place during the telehealth service, there is potential for other people to overhear the conversation between you/your child and the provider.
- Telehealth services may be stopped and in-person visits may be needed if the information obtained through telehealth is not sufficient for medical decision making of if I decide to discontinue the use of telehealth for any reason.
- Assessing and evaluating threats and other emergencies may be more difficult than during an in-person visit. If the session is interrupted for any reason, such as technological connection failure, and you are having an emergency, do not call your provider back; instead, call 9-1-1, or go to your nearest emergency room.

Patient Rights and Privacy

- I have rights as a patient and family. Patient/Family Rights and Responsibilities information is posted at Children's and at childrenswi.org. I may ask for a copy.
- I have rights to privacy. Privacy Practices are posted at Children's and on childrenswi.org. I may ask for a copy. I have reviewed a copy or decided not to review the privacy information.
- Photos and recordings may be taken by Children's for care, training, education or security purposes.
- I cannot take photos or videos of other patients or of staff caring for my child.
- My child's medical records may be shared with health providers, insurance companies and Children's. This is for treatment, payment and health care operations.
- Children's is not responsible for my personal items.

Financial Agreement

- I agree to pay for all charges that are due because of my care and treatment at Children's Hospital and Health Systems, Inc. and any other provider (called "Facility").
- I understand that care and treatment may require labs or other tests that are under the supervision of an independent provider who may bill separately.
- I understand and authorize Facility to file any paper work on my behalf to obtain payment to cover health care costs incurred by me, including any right of the provider to appeal an adverse decision by a payer.
- I hereby irrevocably assign and transfer to Facility and the providers and professionals associated with Facility, for application to my bill for services, all of my right, benefits, and claims (including but not limited to those arising under ERISA) for reimbursement under any federal or state healthcare plan or program (including not limited to Medicare and Medicaid), insurance policy, managed care arrangement, self-funded or other benefit plan, or other similar third party arrangement that covers health care costs for which payment may be available to cover the cost of the services provided to me (collectively, "My Coverage"). This specifically includes filing administrative and other appeals and arbitration/litigation in Facility's name on my behalf, and I authorize Facility to retain an attorney of Facility's choice on my behalf for collection of Facility's bills.
- I may have member appeal rights. I understand that I am responsible for all member appeals.
- I understand that if I choose to have My Coverage billed, it is my responsibility to ensure that the rendered service or services are covered by My Coverage.
- I understand that it is possible My Coverage will not pay for the services. Reasons which My Coverage may give for not paying for services include, but are not necessarily limited to: non-coverage, medical necessity, no authorization, services that are deemed experimental, and otherwise based on the limits of My Coverage. I understand that if My Coverage refuses to pay for the services, regardless of the reason My Coverage gives for that refusal, I will be responsible for payment of these services.
- Notwithstanding the above, I reserve and retain any and all rights under My Coverage (including but not limited to those arising under ERISA) related to services provided to me by providers other than Facility.
- If my account becomes delinquent, I understand that, if and as permitted by applicable federal and state law, Facility may access my credit file, place my account with a collection agency for further collection activity (including access to my credit file), and may assess interest to my account. If external collection services become necessary to obtain payment from me, I agree to pay all collection agency and attorney fees, as well as court costs associated with such collection efforts.
- A photocopy of this assignment shall be considered effective and valid as the original.

What this means

- I understand that care and treatment may include labs and tests ordered by a provider that is not employed by Facility.
- The Facility will send their own bills. I agree that all insurance payments will be paid to Facility and to the providers. What I pay depends on my insurance. I am responsible for charges not covered by insurance.
- I give permission to Facility to bill my insurance. I need to check with my insurance to make sure that the care and tests are covered.
- If I don't pay my medical bill, Facility may take action for payment. Facility may access my credit, send my account to a collection agency and may charge me interest.

Communication

- Children's may need to call, email or text me about appointments, treatment, billing and collections.
- Prerecorded messages and auto-dialers may be used to contact me.
- I give you, any agents or agencies hired on your behalf, permission to contact me at any of the telephone numbers and email addresses provided and know it may result in phone or data charges to me.

I have read this information. I hereby give my informed consent for services under the terms stated above. I am legally able to consent for my child. By signing this form, I give my permission for treatment and agree to the terms listed above. This consent form is good for one year.

Signature: X _____
Patient, Parent or Legal Guardian

Relationship to Patient: _____

Date: _____ **Time:** _____

Verbal Consent: ☐ **Yes** _____
Relationship to Patient

_____
CHHS Witness to the Signature

_____
Second CHHS Witness (Only for Verbal Consent)