EAST TENNESSEE Children's Hospital

Patient name: _____

Date of birth:_____

Parent / Guardian's Consent for Treatment, Information Sharing, and Financial Agreement

1. The doctor/staff of East Tennessee Children's Hospital (ETCH) and its Practices have my permission to give medical care to the patient.
2. I give ETCH and its Practices permission to release the patient's health information to referring physicians, specialists, or other providers who may be involved in the patient's treatment. I understand that ETCH and its Practices may exchange this health information electronically through the East TN Health Information Network (etHIN). I understand I can choose not to participate by completing an Opt-Out Form.
3. I understand that the patient's insurance company needs to know about the patient's visit. I allow ETCH and its Practices to give necessary medical information to the patient's insurance company, any government agency, or the State of Tennessee.
4. I understand that an Opt-Out Form is available if I do not agree with any the following statements:
   - I grant permission for the patient's photo to be placed in a confidential medical record for the Providers' reference.
   - I grant permission for ETCH and its Practices to request the patient's Medication History from other providers and from the patient's insurance company(ies).
   - I would like to participate in the eClinical Works Patient Portal and authorize ETCH and its Practices to use my e-mail address for purposes of participation. **Please note: Patients 14 year of age or older must complete Patient Proxy.**
   - If applicable, I understand that ETCH may use leftover biological samples for research or educational purposes, which would normally be discarded. ETCH may share the samples with researchers at ETCH or other places. All personal health information (PHI) is removed before sharing. I understand that the patient does not receive financial compensation, but ETCH may receive compensation. All uses of the samples will be consistent with applicable law.
5. I agree that insurance payments will go directly to ETCH and the physicians, and that any Medicaid or Medicare payments will go directly to ETCH and its Practices . I will provide truthful information on all financial papers.
6. I understand that co-payments are to be made on the date of service. I will pay unpaid account balances that may include deductible and/or co-payment amounts not covered by the patient's insurance. This may include charges for: receiving treatment from a health care provider who is not listed in the patient's insurance plan or insurance mandated referrals not obtained before service. I understand that any unpaid account balances may be turned over to a collection agency. I realize this may affect my credit rating and I may be responsible for all collection and legal fees incurred by ETCH and its Practices to collect the outstanding balance.
7. I understand that if the patient is scheduled for a Well Check appointment and during that appointment the provider finds a condition requiring treatment (such as strep, otitis media, etc.) my insurance could require me to pay a separate co-payment.
8. I understand that if I need to cancel an appointment, I must do so at least 24 hours prior to the appointment time. I understand that the patient must come to all scheduled appointments. I understand that if the patient misses multiple appointments, the patient may be discharged from the practice.
9. I understand that a provider or employee may be exposed to the patient's blood. If that happens, I allow ETCH and its Practices to test the patient's blood for Hepatitis B & C and HIV. This blood testing is free of charge and is confidential.
10. I have received a copy of ETCH's Notice of Privacy Practices. I can get another copy at any time by calling (865) 541-8053. I consent to ETCH and its Practices use of protected health information as described in the Notice. I understand that I must give a separate authorization before any other disclosures may be made.
11. I understand that it is this office's policy to retain a scanned copy of legal documents or guardianship papers if guardianship changes at any time. I understand that the office requires a copy of identification the first time someone presents with a patient. Insurance cards may be requested at each visit.
12. While at the office, I understand that I may not take photos or recordings of procedures, other patients and ETCH staff without permission by ETCH staff.
13. I give consent for the following individuals to bring the patient to ETCH and its Practices for treatment of illnesses or injuries. I hereby give permission to ETCH and its Practices to exchange information with the following individuals. This request will remain in effect until revoked by me in writing.

a) Name: _____ [relationship:_____phone:_____]

b) Name: _____ [relationship:_____phone:_____]

c) Name: _____ [relationship:_____phone:_____]

Signed: _____ Date: _____

Printed name: _____ Relationship to patient: _____

Interpreter's signature: _____ Date: _____

Witness signature:_____ ☐ Received via mail and requires no witness

Form No. 31647 (01/18)