



Patient name: _____

Date of birth: _____

In Locus Parentis Consent to Treat

1. The doctor and 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 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 may exchange this health information electronically through the East Tennessee Health Information Network (etHIN). I understand I can choose not to participate by completing the Opt-Out Form.
3. I understand that the patient's insurance company needs to know about the patient's visit. I allow ETCH to give necessary medical information to the patient's insurance company, any government agency, or the State of Tennessee.
4. 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. I will provide truthful information on all financial papers.
5. I understand that the patient may receive treatment from a health care provider who is not listed in the patient's insurance plan. I understand the financial responsible party may receive a separate bill for the health care provider for the amount not paid by the patient's insurance.
6. I understand that if the patient's insurance plan requires a referral from the primary care physician, the referral must be obtained before the visit to ensure the patient's maximum benefit from the insurance plan. I understand if the referral is not in place, I must take full responsibility for payment due.
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.) the patient's insurance could require 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 to test the patient's blood for Hepatitis B & C and HIV. This blood testing is free of charge and is confidential.
10. 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.
11. 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's 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.
12. 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.

Please sign here to show that you understand and agree to the items above, and complete the affidavit on the following page:

Signed: _____ Date: _____

Printed name: _____ Relationship to patient: _____

Interpreter's signature: _____ Date: _____

Affidavit of adult standing in loco parentis (in place of the parent) for obtaining health care and making health care decisions:

State of Tennessee

County of _____

_____ (affiant's name), being duly sworn, declares under penalty of perjury as follows:

- 1. I am 18 years of age or older.
- 2. I have taken responsibility for obtaining health care for, and making health care decisions on behalf of: _____ (patient's name).
- 3. I am the patient's (check one): ___ non-custodial parent ___ grandparent
 ___ step-parent ___ aunt or uncle ___ sibling
 other family member (specify): _____

(affiant's signature)

Sworn to and subscribed before me this _____ day of _____, _____.

(notary's signature and seal)

My commission expires: _____

Note that this Affidavit expires 60 days from the date of signature above.