EAST TENNESSEE Children's Hospital

Patient name: _____

Date of birth: _____

Adult Patient Consent for Treatment, Information Sharing, and Financial Agreement

1. The doctor and staff of East Tennessee Children's Hospital (ETCH) and it's Practices have my permission to give medical care to the patient.
2. I give ETCH permission to release my health information to referring physicians, specialists, or other providers who may be involved in the my 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 my insurance company needs to know about my visit. I allow ETCH to give necessary medical information to my 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 I may receive treatment from a health care provider who is not listed in my insurance plan. I understand that I may receive a separate bill for the health care provider for the amount not paid by my insurance.
6. I will pay the deductible and/or co-payment amounts and will pay for charges not covered by my insurance. I understand that co-payments are to be made on the date of 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 to collect the outstanding balance.
7. I understand that if my insurance plan requires a referral from the primary care physician, the referral must be obtained before the visit to ensure the maximum benefit from the insurance plan. I understand if the referral is not in place, I must take full responsibility for payment due.
8. I understand that if I am 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.
9. 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 if I miss multiple appointments, I may be discharged from the practice.
10. I understand that a provider or employee may be exposed to my blood. If that happens, I allow ETCH to test my blood for Hepatitis B & C and HIV. This blood testing is free of charge and is confidential.
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 my photo to be placed in a confidential medical record for the Providers' reference.
    - I grant permission for ETCH and it's Practices to request the my 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 it's Practices to use my e-mail address for purposes of participation.
    - 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 I do not receive financial compensation, but ETCH may receive compensation. All uses of the samples will be consistent with applicable law.
13. I give consent to exchange information regarding my healthcare or financial matters 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:_____]

d) Name: _____ [relationship:_____ phone:_____]

e) Name: _____ [relationship:_____ phone:_____]

Signed: _____ Date:_____

Patient printed name: _____

Interpreter's signature: _____ Date:_____

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

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.