Children's Hospital of The King's Daughters Health System

TREATMENT AND PAYMENT ACKNOWLEDGMENT/CONSENT

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

CONSENT FOR TREATMENT

I hereby request and consent to medical and/or diagnostic treatment, including admission if deemed necessary, by Children's Hospital of The King's Daughters, Incorporated ("CHKD"), Children's Medical Group, Inc. ("CMG"), Children's Surgical Specialty Group, Inc. ("CSSG") (CHKD, CMG, and CSSG are collectively referred to herein as "Children's Hospital of The King's Daughters Health System" or "CHKDHS") and/or Children's Specialty Group, PLLC ("CSG"), and hereby authorize such entities and their physicians (and whomever he/she may designate as his/her assistant(s), including Residents and any CHKD professional staff physician) and employees to treat myself or minor(s) in my legal custody, including stepchildren, in ways they determine to be therapeutically necessary. I understand that this treatment may include tests (lab/diagnostics), examinations, administration of medications, and medical or surgical procedures. I understand that during treatment, the possibility exists for health care workers to become directly exposed to the individual's blood or body fluids. Virginia law authorizes health care providers to test patients for HIV and hepatitis B & C antibodies when a health care provider or any person employed by or under the direction and control of a health care provider is exposed to the body fluids of a patient on the basis of deemed consent. In the event of exposure, I understand that I will be deemed to have consented to testing, and consent to release test results to the health care worker who may have been exposed. Prior to testing, I will be informed and given an opportunity to ask questions. I consent to the release of prescription history from any drug pharmacy or drug monitoring agency to my physician or healthcare provider. I further consent to the taking of photographs for treatment and/or payment purposes.

OBLIGATION OF PAYMENT

I irrevocably direct and assign payment from my insurance company, Medicaid, Medicare, Tricare, or other provider of health care benefits to CHKDHS and/or CSG for services rendered. **I understand that my insurance policy is a contract between my insurance company and me, and that I am responsible to CHKDHS and/or CSG for any charges not covered by my insurance, including co-payments, deductibles, and fees for non-covered services. Since most physicians are not employed by the hospital, the hospital and physician will bill separately for services rendered. Some insurance plans require the laboratory and/or radiology department performing tests to bill for such diagnostic tests. In these instances, I understand that I will receive a separate statement and bill from the laboratory and/or radiology department performing the test.** If all charges are not paid when due to CHKDHS and/or CSG, the undersigned agrees to pay all costs of collection, including collection agency and attorney's fees in an amount not to exceed THIRTY THREE AND ONE-THIRD PERCENT (33-1/3%) of the balance placed with agency and attorney, which shall be deemed incurred upon referral.

Date: __________ Initials: __________

BALANCES DUE AND BILLING QUESTIONS

Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement. Co-payments and other self-pay amounts are due prior to leaving the hospital and/or practice. I have been informed that a fee of $25.00 may be applied to my account for any returned checks. The RETURNED CHECK FEE is only payable in cash or by money order. Please direct all billing inquiries to the CHKDHS and/or CSG Billing Representative where you received your care.

ACKNOWLEDGMENTS/CERTIFICATIONS

I, the Parent/Legal Guardian/Patient, acknowledge and certify the following:

- I received a medical screening and stabilization treatment prior to being asked about financial information while seeking care for a deemed medical emergency.
- I was provided (a) the "Patient/Family Rights & Responsibilities" and (b) the Organized Healthcare Arrangement "Notice of Privacy Practices" on the date of this Agreement and was given an opportunity to ask questions about the information provided.
- I have read and agree to the terms of the "Patient Financial Policy". I certify that I understand the payment terms contained in this form.
- If the email address is provided, I consent to CHKDHS' & CSG's use of unsecured email to send me a patient satisfaction survey link. The email received will include the patient's name and the physician seen.
  E-mail address approved for use:_ _
- If the mobile phone number is provided, I consent to CHKDHS's and CSG's use of unsecured text messaging to send me appointment reminders. The text received may include the patient's name, provider's name & practice for the scheduled appointment, the office phone number, the date & time of the appointment, & the location. Mobile phone number: (________)-________ - _____________
- I certify that this form has been fully explained to me and I understand the contents of this form and that I am the patient or the patient's parent/legal guardian and have the authority to request this treatment. Furthermore, I permit a copy of this document to be used in place of the original. I certify that all statements are true and correct and I understand that false statements or documents or concealment of a material fact may be prosecuted under federal or state laws.

Advance Directive to be completed if patient is an adult (18 years or older): Does the patient have an advance directive? ____Yes ____No

Thank you for selecting Children's Hospital of The King's Daughters Health System as your Health Care Provider

PATIENT(S) NAME (please print)	DATE OF BIRTH

______________________ SIGNATURE OF PATIENT/LEGAL GUARDIAN

______________________ RELATIONSHIP TO PATIENT/LEGAL AUTHORITY

______________ DATE

________ TIME

Witness:______________________________ Date:_____________ Time:____________

For office use only:

2nd Witness: (Verbal Consent Only)	Date	Name of Person Accompanying Patient