(Place patient label here if blank)

Akron Children's Hospital

GENERAL CONSENT

CONSENT FOR MEDICAL TREATMENT:

I* and/or my parents(s) or guardian(s) consent to let the physicians, nurses, other health care providers, and employees of Akron Children's Hospital, attending physicians and other physicians, or any of their assistants or designees, do all things that may be needed to diagnose, treat and care for the needs of the above-referenced patient.

Children's is a teaching hospital and I understand and agree that people who are in training, including, but not limited to, fellows, residents, and students, may assist or participate in my care.

I understand and agree that Children's may take photos, video, or audio recording of me and use them for clinical, legal purposes and quality improvement purposes.

I understand and agree that Children's may at its discretion provide certain services to me by remote means called "telehealth".

Children's may keep, preserve and use, or properly dispose of any tissue, samples, parts or organs that are taken during operation(s) or procedure(s).

I understand that the practice of medicine is not an exact science and that no guarantees have been made about the results of my examination or treatment at Children's.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:

I agree to pay all bills for my care, including bills that insurance benefits do not pay. This includes bills for Children's, physicians or other entities that provided services during my care. I authorize Children's to bill my insurance carrier and request that payments be made directly to Children's. I assign to Children's, my physicians and other healthcare professionals involved in my care, all of my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, Tricare, any other program for which benefits may be available to pay Children's for the services provided to me, or other payments or judgments. If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payer regarding those services, I understand that a financial agreement will be established. I agree to cooperate and provide complete and accurate information as needed to establish my eligibility for such benefits.

PERSONAL VALUABLES:

I understand that I am responsible for any items I choose to keep with me while I am at Children's. Children's is not responsible for any lost, stolen or damaged personal items and is not responsible to replace such property.

PATIENT RIGHTS/PRIVACY INFORMATION:

I understand I have the right to take part in decisions about my healthcare and plan for treatment. I have the responsibility to wear my patient identification at all times while at Children's hospital campus. In addition, my parents/family/guardian/visitors have the responsibility to wear their Children's identification at all times while at Children's hospital campus. I have received, read, or had explained to me, and acknowledge receipt of the following documents and/or information, and all my questions have been answered.

- Patient Rights and Responsibilities
- Complaint/Grievance Procedure
- Health Information Exchange Brochure
- HIPAA Notice of Privacy Practices
- Advance Directive Information (Patients 18 years & older)
- Free Hospital Care Information
- "An Important Message from Medicare" (Medicare patients)
- "An Important Message from Tricare" (Tricare patients)

*Throughout this document the use of the term "I" will refer to "I and/or my parents or guardians." The use of the term "me" "myself" or "my" shall refer to the patient. The use of "Children's" will refer to Akron Children's Hospital, its physicians, nurses, other health care providers, employees, attending physicians and other physicians, and their assistants or designees.

(Place patient label here if blank)

Akron Children's Hospital

GENERAL CONSENT

AUTHORIZATION TO COMMUNICATE:
I understand that Children's uses various communication methods including voice calls, computerized calls, computerized text messaging, email, fax, auto-dialed calls, and pre-recorded messaging for the purposes of sharing clinical/medical results, scheduling appointments, sending appointment reminders, obtaining patient feedback, and communicating/ discussing financial responsibilities. By signing this form, I am granting permission to Children's to use all phone numbers and email addresses that I have supplied to contact me regarding this current visit and any future visits. I will be given the opportunity to opt out of future text, email or phone communications at any time. I understand that my opting out of future text, email or phone communications will not affect, directly or indirectly, my right to receive health care services from Children's.

ALL PATIENTS COVERED BY MEDICAID:
I was asked whether any insurance other than Medicaid may cover services provided by Children's. If there is other insurance coverage, I gave that information to Children's.

I have read this consent form or have had it read to me, and it has been explained to my satisfaction. This consent is valid until revoked by me in writing to Children's.

By signing below, I acknowledge that I understand and accept the terms of this consent and confirm that I have legal ability to consent for the treatment.

or

Patient Signature *(If 18 years or older.)* Date Time

Signature of Parent/Guardian *(If patient is less than 18 years.)* Date Time

Print Name of Parent/Guardian

Witness to Signature #1 Date Time

Witness to Signature #2 Date Time

(Two witnesses required for telephone consent ONLY)

Telephone Consent Obtained

By: _____ _____ _____
NAME EMPLOYEE NUMBER TITLE

FOR OFFICE USE ONLY - ***PATIENTS/PARENTS, PLEASE DO NOT WRITE IN THIS SPACE.***

COMPLETE IF PATIENT IS 18 YEARS AND OLDER.
Advance Directives: Does an Advance Directive Exist?

Medical? ☐ Yes ☐ No
Psychological? ☐ Yes ☐ No
(Initials) Date Time

If yes, has actual Advance Directive document been placed in the medical record? ☐ Yes ☐ No
(Initials) Date Time

If no, was Advance Directive booklet provided? ☐ Yes ☐ No
(Initials) Date Time

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Rev. 03/19

* C O N S E N T S *