0485

Words Used in This Agreement	*Nicklaus Children's*	Nicklaus Children's Hospital and its clinics and physicians employed by or under contract with Nicklaus Children's Hospital
	Insurance	Patient's insurance company, HMO, PPO, Medicare or Medicaid
	Attending Physician	The doctor who oversees the Patient's care
	Permitted Treatment	The medical care for the Patient during the current illness, as recommended by the Attending Physician

Consent for Treatment

In the capacity provided for below, I authorize Nicklaus Children's and its employees and contractors to provide Treatment to the Patient

1. I understand that Treatment includes:
    - basic treatments
    - physical examinations by the Attending Physician and other licensed personnel or other personnel under the supervision of licensed personnel
    - medical procedures
    - routine and special diagnostic procedures
    - x-ray exams
    - mental health treatment
    - screening for diseases, as deemed necessary by the Attending Physician or others in collaboration with the Attending Physician (such as Chicken Pox, Hepatitis B, German Measles and Tuberculosis)
2. I understand that the Treatment may be received as inpatient or outpatient.
3. I understand that Nicklaus Children's is a teaching hospital. I agree that doctoral students, interns and residents may provide care to the Patient as supervised by the Attending Physician or appropriate licensed personnel.
4. I understand that the Attending Physician who is the person responsible for the delivery of care, treatment, and service is listed at the bottom right hand corner of this page.
5. I understand that a physician may be an independent contractor, and not an employee of Nicklaus Children's Hospital. The independent contracted physician is responsible to explain to me the risks, benefits, and potential complications that may arise in the provision of the treatment, and may ask me to sign a separate consent for his or her services.
6. I understand that treatment may include the use of controlled substances and that the physician will discuss the risks and benefits of the use of controlled substances, including the risk of abuse and addiction.

Consent for Release of Personal Information for Fund Raising

I understand Nicklaus Children's may use certain information (name, address, telephone number, dates of service, age, and gender) to contact me in the future to raise money for Nicklaus Children's Hospital. Nicklaus Children's may also provide my name to their institutionally related foundation, for the same purpose. The money raised will be used to expand and improve the services and programs Nicklaus Children's provides to the community.

Photographs and Videotaping

In the capacity provided for below, I authorize the taking of photographs and videotapes of the Patient during the Patient's Treatment. I also authorize the use of such photographs and videotapes by Nicklaus Children's or its designees for teaching and/or research purposes. I understand I may opt out of this option.

Consent for the Use or Disclosure of Health Information by the Patient/Family Services Department

I understand the mission of Patient/Family Services Department is to support the patient's health needs by coordinating ongoing medical, therapeutic, financial and daily living needs during and after discharge from Nicklaus Children's Hospital. These activities often require social workers to use or disclose the patient's private health information to appropriate agencies.

By signing this authorization, I am authorizing Nicklaus Children's Hospital Patient/Family Services staff to use or disclose the patient's health information to the following types of organizations:

Advocacy/Legal Services	Embassies/Consulates	Home Health Services	Special Health Needs Resources
Charitable Organizations	Equipment Companies	Housing/Shelters	Therapeutic Services
Daily Living Resources	Patient Family or Support Systems	Insurance Companies	Transportation Services
Educational Resources	Government Assistance Programs	Recreational Services	
Others:			

This Authorization applies to all health information, including medical history, mental or physical condition and treatment received including but not limited to HIV, AIDS, mental and substance abuse, and any other private, personal or financial information provided. This Authorization continues to be in effect as long as I am a patient of Nicklaus Children's Hospital and continue to obtain services from Patient/Family Services Department, or until you rescinded in writing.

Your Rights:

- You may refuse to consent to the Use or Disclosure of Health Information by Patient/Family Services Department by crossing out this section and initialing the change.
- You may revoke this authorization at any time. Your revocation must be in writing, signed and delivered to the following address:
  Nicklaus Children's Hospital Health Information Management Department
  3100 SW. 62nd Avenue
  Miami, Florida 33155
- Your revocation will be effective upon receipt, but will not be effective to the extent that the Patient/Family Services Department or others have acted in reliance upon this Authorization.
- Treatment will not be conditioned on your providing or refusing to provide this authorization.

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed by them and no longer protected.

Valuables

I am responsible for everything that I bring to Nicklaus Children's, including, but not limited to, money, jewelry, glasses, dental appliances, documents or other valuable things. I will not hold Nicklaus Children's liable for any of these items if they are lost or stolen.

Patient Identity

It is my understanding that the patient must wear an identification band at all times and that the Patient is not to remove the identification band.

Nicklaus Children's Health System

PATIENT/FAMILY GENERAL CONSENT FOR TREATMENT

NICKLAUS CHILDREN'S HOSPITAL
3100 SW 62 AVENUE
MIAMI, FL 33155
FORM # 798.057.0485 (PA0485)
VERSION 3

Patient Rights and Responsibilities

I have been offered the Patient's Bill of Rights and Responsibilities.

Telephone Consumer Protection Act

In consideration for the services rendered to me, I hereby consent to receive messages, including texts or SMS messages, and calls on behalf of the healthcare provider and/or its agents, employees, contractors, or others for healthcare, operations or payments purposes, at the number provided by me at scheduling/registration or thereafter, including my cell phone number and email address (which is my personal email address), including calls or messages using any form of computer assisted dialing or telephone equipment.

Notice of Privacy Practices

Either now or in the past, I have been offered a copy of the Notice of Privacy Practices.

Insurance

1. In the capacity provided for below, I agree to provide to Nicklaus Children's the Patient's Insurance card and hereby authorize them to make a copy of it.
2. Except in connection with an Emergency Medical Condition, as defined by state and federal law, where prior approval from the Insurance will not be sought, I understand that certain steps may have to be met before the Patient's Insurance is required to pay benefits. Except in the Emergency Medical Condition, where no prior conditions have to be met, I am responsible for fulfilling those conditions prior to admission. Except in the of an Emergency Medical Condition, where no prior approval is permitted to be sought, it is my responsibility to call the Insurance company to get their approval for the admission of the Patient or the provision of services to the Patient prior to the time the Patient is provided Treatment or is admitted. It is not Nicklaus Children's responsibility to obtain this prior approval.
3. The Insurance will only pay for certain services that it deems medically necessary covered services, as more particularly described in the agreement with the Insurance. If the Patient's Insurance decides that a service provided by Nicklaus Children's is not a covered service, or that a service provided by Nicklaus Children's', even though it may be a covered service, is not otherwise medically necessary, it will deny payment for that service. In such event, I agree to be personally and fully responsible for paying for such services for which the Insurance is not liable.

Member Name:______________________________ Patient Name:______________________________

ID#:______________________________ Date of Service:______________________________

Coordination of Benefits

Dear Member:

Your insurance contract provides for benefits to be coordinated with other medical insurance by which you may be covered. The primary carrier pays first when there is more than one (1) Insurance Company or Health Care Provider. Please sign this form. Complete Section I, II and III, if applicable.

In order to expedite the claim process; please complete the following information:

- SECTION I

  Does the patient have any other health insurance? Yes ☐ No ☐

  If yes: Company Name:______________________________

  Policy Number:______________________________

  Effective Date:______________________________

- SECTION II

  How did the accident or injury occur?

  Auto ☐ Home ☐ School ☐ Work ☐ Other ☐

  Date of accident:____________________

  Details:______________________________

  ____

  ____

  Was a third party responsible for your injury? If so, provide the following:

  Name of individual and/or company:______________________________

  Name and address of attorney representing third party, insurance company of party responsible:

  ____

- SECTION III (Use in the event of auto accident only)

  Were you in your own vehicle or someone else's vehicle? ______________________________

  Name of insurance company and telephone number:______________________________

  ____

  Policy #:____________________ Accident Claim #:____________________

  Does an Attorney represent you? _______ If so provide attorney's name, address, and phone number:

  ____

Consent for Release Of Information

In the capacity provided for below, I authorize Nicklaus Children's to give any medical information that Nicklaus Children's has in its possession to other healthcare providers and any Insurance or any person who may have responsibility to pay for or reimburse for my health care for TPO (as defined below) when it's needed to care for the Patient. As described in the Notice of Privacy Practice (NOPP) which I have received, Nicklaus Children's may disclose the patients' health information to any persons and entities outside of Nicklaus Children's Hospital for "Treatment, Payment or Healthcare Operations ("TPO") such as, but not limited to, coordinating ongoing medical, therapeutic, financial and daily living needs during and after discharge from Nicklaus Children's.

Assignment of Insurance Benefits

In the capacity provided for below, I want Patient's Insurance to pay Nicklaus Children's first, before paying any other provider of health care services. I authorize the Patient's Insurance to pay these benefits (including, without limitation, liability insurance) directly to Nicklaus Children's.

Guarantee of Payment

1. I understand that my medical bills will have different types of charges:
   - Patient services
   - Physician fees (for example, attending physician, consulting physician, anesthesiologist, etc.)
   - Physician fees for interpretation of various procedures (for example, radiologist, pathologist, etc.)
2. I agree to pay all charges for non-covered services and to cause the Patient's Insurance to pay for covered services charges, as the case may be, at the time of service or when I receive the bill(s).
3. If Nicklaus Children's cannot collect payment from the insurance or from me when the insurance is not liable for such services, then I will also be responsible to pay for any of Nicklaus Children's' costs from a collection agency, attorney, or court. I authorize Nicklaus Children's and its agents and representative, including without limitation, the attending physician and any physician who provides services to the patient related to the services pertaining to this consent, and their respective agents and representative, to call me on my home and cell phones using an automatic dialing system.

Statement of Truthfulness

I have provided information to Nicklaus Children's about the Patient's Insurance. This information is true and correct. I understand and agree that if any of the information is not true or correct, then I may be liable for damages and penalties under this agreement and Florida law.

I understand that notwithstanding my ability to pay or the patient's ability to pay, the patient has a right to a medical screening examination, and if an emergency medical condition exist, the right to receive stabilizing treatment. Nicklaus Children's stands ready and willing to provide these services, even if the patient has no Insurance.

Upon request a copy will be provided to the consenting person.

I certify that I have read and understand this consent.

I understand that the services being provided are being furnished by a department of Nicklaus Children's Hospital.

____________________ ____________________/____________________

NAME (Print full name) RELATIONSHIP TO PATIENT/CAPACITY SIGNATURE

____________________ ____________________/____________________

WITNESS (Print full name) TITLE SIGNATURE

DATE:____________________ TIME:________________ a.m. p.m.

Required for Telephone Consent:

____________________ ____________________/____________________

SECOND WITNESS (Print full name) TITLE SIGNATURE

If relationship to patient is other than parent or legal guardian (see copy of legal guardianship papers attached) the following attempts were made to contact the person who has power to consent:

Date: **Time:** **Name of Person:** **Relationship to Patient:**

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