0 0 7 5 9

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

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

TREATMENT AND PAYMENTACKNOWLEDGMENT/CONSENT

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 in a manner that may transmit HIV or the Hepatitis A or B viruses. 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/videos for treatment, security, public health, healthcare operations, and/or payment purposes. Date: _____ Initials: _____

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 & one-third % (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. All billing inquiries can be directed to the CHKDHS and/or CSG Billing Representative where care was received. Date: _____ Initials: _____

COMMUNICATION PREFERENCE

- If email address(es) is/are provided, I consent to CHKDHS' and/or CSG's use of encrypted email to send me communications that may include protected health information.
- If mobile phone numbers is/are provided, I consent to CHKDHS and/or CSG's use of unsecured SMS text messaging to send me communications that may include protected health information.

By signing this consent form, I acknowledge that I have the authority to provide consent and am granting permission to CHKDHS and/or CSG or their affiliates, clinical providers, business associates, billing services, collection agencies, agents, or third parties who may act on their behalf to contact me for any reason or purpose, including those related to my account, insurance, billing, payment, and/or the care rendered on the mobile phone number(s) provided on this or other form(s) or updated at a later time. I understand that I may choose to grant permission to contact me via phone call and text message, or phone call only (no texts). Consent is not required; I may opt-out of communications sent to my cell phone number(s). I retain the right to revoke permission at any time. I understand that communications may be made as a direct dial call or through the use of SMS text messages, live, pre-recorded or artificial voice messages, and/or the use of an "automated telephone dialing system," computer-aided technologies, or "autodialer". Depending on my mobile service plan, message and data rates may be assessed by my mobile provider. I may withdraw consent or opt-out at any time by providing written notice to Physician Practice Management, by emailing Text.Opt@chkd.org, by calling CHKD at (757) 668-8577, or by visiting the website www.chkd.org/TextOpt . Responding to SMS text messages with "STOP" will also withdraw my consent. I understand that the person signing is not required to sign the agreement as a condition of securing or receiving any services with CHKDHS and/or CSG.

Date: _____ Initials: _____

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 offered (a) the "Patient/Family Rights & Responsibilities" form and provided (b) the Organized Healthcare Arrangement "Notice of Privacy Practices" form 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.

I certify that this form has been fully explained to me, that I have had any necessary communication assistance, 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. I acknowledge that any form completed by CHKDHS and/or CSG shall not be changed or altered by a parent/guardian/patient and understand that if it is changed or altered, it may jeopardize my child's health or safety based on provider(s)'s recommendation(s). Date: _____ Initials: _____

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

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