0 2 2 7 7

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

CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS HEALTH SYSTEM, INC.

AUTHORIZATION TO GIVE CONSENT FOR MEDICAL TREATMENT

Child/Patient Name(s):	Date of Birth:	Hospital Medical Record #:

Until revoked by me in writing, the following persons are authorized to act on my behalf:

(1) to give consent to medical and/or diagnostic treatment in Children's Hospital of The King's Daughters Health System (CHKDHS) physician offices, outpatient clinics/departments (including Lab and Radiology), and outpatient therapy departments as deemed necessary, by Children's Hospital of The King's Daughters, Inc., ("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") of my child named above;

(2) to give consent for testing my child's blood for HIV antibodies in accordance with the laws of Virginia which authorize health care providers to test patients when a health care provider is exposed to the body fluids of a patient;

(3) to assign benefits of third party payors for direct payment to CHKDHS and/or CSG; and

(4) to receive financial information regarding my child's health care and/or medical information about my child's condition, treatment or health care received at CHKDHS and/or CSG.

I agree that the following persons, 18 years of age or older, are authorized to sign on my behalf thus acknowledging the following statement and binding me to its terms in my absence: The undersigned parent and/or legal guardian agree that in consideration of services rendered to the patient, each of them jointly and severally, will pay and guarantee payment to CHKDHS and/or CSG. I furthermore 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 my insurance policy is a contract between my insurance company and me, and 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 or radiology department performing tests to bill for such diagnostic tests. In these instances, I understand I will receive a separate statement and bill from the laboratory 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.

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. In the event my check is returned or declined, I agree to pay any returned check fees (payable only in cash or by money order). Please direct all billing inquiries to the CHKDHS and/or CSG Billing Representative where you received your care.

AUTHORIZED PERSONS:

First Name	Last Name	Phone	Relationship to Child	Date
First Name	Last Name	Phone	Relationship to Child	Date
First Name	Last Name	Phone	Relationship to Child	Date

Parent/Legal Guardian:_____ Date_____

Witness (CHKD employee only):_____ Date_____

DO NOT USE AS CONSENT FOR INPATIENT, ER, OR DAY SURGERY VISITS