EAST TENNESSEE Children's Hospital

Adult Patient Consent for Treatment, Information Sharing, and Financial Agreement

Patient name: _____ Date of birth:_____

1. The doctor and staff of East Tennessee Children's Hospital (ETCH) and it's Practices have my permission to give medical care to the patient.
2. I give ETCH permission to release my health information to referring physicians, specialists, or other providers who may be involved in the my treatment. I understand that ETCH may exchange this health information electronically through the East Tennessee Health Information Network (etHIN).
3. I understand that my insurance company needs to know about my visit. I allow ETCH to give necessary medical information to my insurance company, any government agency, or the State of Tennessee.
4. I DO ☐ DO NOT ☐ give ETCH permission to request my Medication History from other providers and from my insurance company(ies).
5. I agree that insurance payments will go directly to ETCH and the physicians, and that any Medicaid or Medicare payments will go directly to ETCH. I will provide truthful information on all financial papers.
6. I understand that I may receive treatment from a health care provider who is not listed in my insurance plan. I understand that I may receive a separate bill for the health care provider for the amount not paid by my insurance.
7. I will pay the deductible and/or co-payment amounts and will pay for charges not covered by my insurance. I understand that co-payments are to be made on the date of service. I understand that any unpaid account balances may be turned over to a collection agency. I realize this may affect my credit rating and I may be responsible for all collection and legal fees incurred by ETCH to collect the outstanding balance.
8. I understand that if my insurance plan requires a referral from the primary care physician, the referral must be obtained before the visit to ensure the maximum benefit from the insurance plan. I understand if the referral is not in place, I must take full responsibility for payment due.
9. I understand that if I am scheduled for a Well Check appointment and during that appointment the provider finds a condition requiring treatment (such as strep, otitis media, etc.) my insurance could require me to pay a separate co-payment.
10. I understand that if I need to cancel an appointment, I must do so at least 24 hours prior to the appointment time. I understand that if I miss multiple appointments, I may be discharged from the practice.
11. I understand that a provider or employee may be exposed to my blood. If that happens, I allow ETCH to test my blood for Hepatitis B & C and HIV. This blood testing is free of charge and is confidential.
12. I have received a copy of ETCH's Notice of Privacy Practices. I can get another copy at any time by calling (865) 541-8053. I consent to ETCH's use of protected health information as described in the Notice. I understand that I must give a separate authorization before any other disclosures may be made.
13. I ☐ would or ☐ would not like to participate in the eClinical Works Patient Portal and authorize ETCH to use my e-mail address for purposes of participation.
14. I give consent to exchange information regarding my healthcare or financial matters with the following individuals. This request will remain in effect until revoked by me in writing.

a) Name: _____ [relationship:_____ phone:_____]

b) Name: _____ [relationship:_____ phone:_____]

c) Name: _____ [relationship:_____ phone:_____]

d) Name: _____ [relationship:_____ phone:_____]

e) Name: _____ [relationship:_____ phone:_____]

I understand this consent will be used in its entirety across all eClinicalWorks practices that are owned or affiliated with East Tennessee Children's Hospital.

Signed: _____ Date:_____

Patient printed name: _____

Interpreter's signature: _____ Date:_____

Witness signature: _____ ☐ Received via mail and requires no witness

Affidavit of adult standing in loco parentis (in place of the parent) for obtaining health care and making health care decisions:

State of Tennessee

County of _____

_____ (affiant's name), being duly sworn, declares under penalty of perjury as follows:

1. I am 18 years of age or older.
2. I have taken responsibility for obtaining health care for, and making health care decisions on behalf of:_____ (patient's name).
3. I am the patient's (check one): _____non-custodial parent _____grandparent

   _____ step-parent _____aunt or uncle _____sibling

   other family member (specify): _____

_____
(affiant's signature)

Sworn to and subscribed before me this _____ day of _____, _____.

_____
(notary's signature and seal)

My commission expires: _____

Note that this Affidavit expires 60 days from the date of signature above.