GENERAL CONSENT

Name: ______________________________
Medical Record Number: ________________
Date of Birth: __________________________
Date of Service: ________________________

PATIENT AND/OR LEGAL GUARDIAN MUST REVIEW AND COMPLETE THE FOLLOWING INFORMATION:

I. Consent for Care and Treatment

I voluntarily consent to the performance of hospital services (i.e. treatment, injections, medications) and the use of all means of diagnostic and laboratory work of any kind, including but not limited to the taking of blood, tissue, fluids and other body samples, photographs and video recordings, x-rays or other radiographic procedures which are deemed necessary or prudent by the attending physician, his/her designee or any other member of the professional staff ("practitioner") of Dayton Children's Hospital (Dayton Children's). If I decide to stop medical care against the advice of practitioners, I understand that Dayton Children's and its practitioners are not responsible for any adverse outcomes from my decision. I understand that Dayton Children's functions in part as a teaching institution and that treatment may be photographed and/or video recorded and utilized for education and/or performance improvement. I acknowledge that I/my child/my ward may be included in Dayton Children's patient directory and may be included in teaching or education programs. I authorize Dayton Children's to keep, preserve, use, or properly dispose of any tissues, fluid or other bodily samples that are taken during the course of treatment.

If I am an Ambulatory (Clinics, Laboratory, Radiology, other diagnostic areas, etc.) patient, I agree to allow this consent to be effective for three years or until I notify Dayton Children's in writing that I want to change or revoke it. If there is a change in custody of my child, I will notify Dayton Children's during my child's next visit.

II. Release of Information

I understand that my/my child's/my ward's health information will be used for medical care, administrative, instructional and research purposes. I understand that the release of information may include details of diagnosis and treatment, including drug and/or alcohol use, HIV infection, diagnosis of AIDS or AIDS-related conditions, and mental health diseases/disorders. The authorization for the release of HIV-related information shall be effective for one year from the date of service.

I authorize the release of information from my/my child's/my ward's medical record when necessary to process claims for financial coverage and/or reimbursement for services rendered at Dayton Children's. I authorize the release of this information to third party payors, including insurance companies and/or government agencies, their respective agents, my employer, or to Dayton Children's agents to assist in determining eligibility requirements, to the extent necessary to secure payment.

I have been informed of and offered a copy of Dayton Children's "Notice of Privacy Practices," which describes how Dayton Children's may use and disclose my/my child's/my ward's personal health information.

III. Patient Rights and Responsibilities

I have the right to take part in decisions about my/my child's/my ward's medical care and treatment plan. I/my child/my ward have the right to an anonymous HIV test, and a list of facilities providing anonymous testing will be provided upon request. I have been informed of and offered a copy of the "Patients Rights and Responsibilities" brochure. When applicable, I/my child/my ward have the responsibility to wear patient identification at all times. I understand that I am fully responsible for all personal possessions that are kept or brought to Dayton Children's.

IV. Price Disclosure

Pursuant to Section 3727.42 of the Ohio Revised Code, Dayton Children's has compiled and made available for public inspection a list of the usual and customary charges for room and board and all the usual and customary charges for a selected number of x-ray, laboratory, emergency room, operating room, physical therapy, occupational therapy and respiratory services.

V. Independent Practitioners

I understand that some practitioners who provide professional services at Dayton Children's are independent practitioners and are not employees or agents of Dayton Children's. I understand that Dayton Children's is not responsible for the acts or omissions of these practitioners. A list of practitioners employed by Dayton Children's is available at www.childrensdayton.org or upon request.

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Patient or Legal Guardian Initials

VI. Assignment of Benefits, Medicare Authorization, and Agreement for Payment

Assignment of Benefits: In consideration for services rendered, I hereby assign and transfer to Dayton Children's any and all of the following to which I may be entitled either in law or in equity: benefits, monies, and any sums or other credits payable to me/my child/my ward for hospitalization, sickness, or otherwise under any hospitalization, sickness, accident, or other insurance policy, or any other state, federal, or private insurance policy which might be applied toward payment of or reimbursement for any and all services rendered or goods supplied as a result of the hospitalization and/or treatment contemplated by this agreement. If for any reason I am unable to assign or transfer such rights, I hereby authorize and appoint Dayton Children's as my agent with respect to the pursuance, receipt and application of such funds as it sees fit.

Medicare Authorization: I certify this information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf to Dayton Children's or any physician rending service during my treatment(s).

Payment for Hospital Care: I or my designated agent for myself/my child/my ward will be responsible and assume the obligation to pay Dayton Children's all costs during in-patient or out-patient care. I or my designated agent further agree to pay insurance deductibles and/or estimated co-payment amounts at the time of admission or work out a satisfactory monthly payment plan. At all times I, or my designated agent, will remain primarily responsible for the costs of said hospital care and treatment and for obtaining any necessary authorizations for such care and treatment. Assessment for emergency medical conditions and stabilizing treatment for such conditions within the capability of Dayton Children's will be provided, regardless of ability to pay.

I understand that insurance benefits for professional services rendered by independent practitioners are assigned to and may include any organizations that provide a billing service on behalf of or in conjunction with those physicians for payment of services rendered.

SIGNATURES

By my signature below, I certify that I have read and understood the items on this General Consent, that I have given truthful information about my/my child's/my ward's identity, demographic & financial/insurance information, and that I am either the patient or the patient's legally authorized representative. The above named patient & guarantor have no other health insurance or medical coverage other than what I have provided. I certify that my questions (if any) have been answered to my satisfaction.

Signed ______________________________ ___________ _____ Print Name ______________________________
Patient or Legal Guardian (if patient < 18yrs) Date Time

Signed ______________________________ ___________ _____
Witness Date Time

HOSPITAL USE ONLY

Check One: ☐ *Verbal/Phone Consent Obtained from Legal Guardian*
☐ *Unable to Reach Legal Guardian; Consent Obtained from Administrator On-Call*

Consent Obtained From ______________________________ *On* ___________ *At* _________
Name of Legal Guardian or Administrator On-Call *Date* *Time*

Signed ______________________ ___________ *Signed* ______________________ ___________
Individual Requesting Consent *Date and Time* *Witness (required when from legal guardian)* *Date and Time*

Comments ____

ALTERATIONS TO THIS DOCUMENT ARE PROHIBITED