

CONSENTS/AGREEMENTS
MENTAL HEALTH SERVICES



Patient Name: _____ (the "Patient")

1. **Consent for Treatment:** I, the undersigned, authorize and consent to Children's Specialized Hospital and its Medical and Professional Staff (the "Hospital") to provide and administer any and all treatment as deemed advisable to the Patient for continuum of care. The following have been discussed with me by my health care professional: (a) the current diagnosis and the general course of treatment and therapy; (b) the risks, benefits, and alternative treatments; (c) the relevant risks and benefits of such alternative treatments; (d) clinical outcomes if I do not elect to have the proposed course of treatment; and (e) the likelihood of achieving care, treatment and service goals.
2. **No Guarantees/Unforeseen Conditions:** I am aware that there are certain risks and hazards connected with any treatment that may result in complications or other consequences. I also know that no one can predict with certainty the results of medical treatment and surgery because the practice of medicine is not an exact science. I acknowledge that no guarantees or assurance have been made to me concerning the patient's treatment in the Hospital. I am aware that unforeseen conditions may arise during the patient's treatment by the Hospital which would require more treatment than the originally anticipated.
3. **Consent for Testing:** In the event that any healthcare provider or first responder (including emergency medical service workers and police officers) involved in the Patient's care is exposed to the Patient's blood or bodily fluids and makes a request for testing and results of such testing, I consent to the drawing of blood for the purpose of testing it for various blood-borne pathogens including, but not limited to, Human Immunodeficiency Virus (HIV) and Hepatitis B and C. I understand and agree that the results of the blood test shall be released to me and to the healthcare provider/first responder exposed to the Patient's blood or bodily fluids. To the extent possible, these results will be provided to the healthcare provider/first responder without disclosing the Patient's name.
4. **Teaching Institution:** I understand that the Hospital is a teaching institution and that my child may be treated by residents and students in the course of their residency and/or rotation. I understand that the residents and students are providing these services under appropriate supervision.
5. **Appeals.** I understand that I have a statutory right as a covered patient (legal guardian as applicable) to consent to representation by my health care provider in an appeal of an adverse utilization management determination presented to the Independent Health Care Appeals Program Application. (Refer to attached document: **APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS**).
6. **Assignment of Benefits:** I hereby assign, transfer, and set over to the Hospital and its related health care providers and entities, all monies and/or benefits to which I may be entitled from government agencies, including the Medicare and Medicaid Programs, insurance carriers, HMOs, or others who are financially liable for the Patient's hospitalization and medical care to cover the costs of the care and treatment rendered.
7. **Financial Agreement/Precertification:** I agree to pay the Hospital for all services rendered to the Patient by the Hospital for which I am financially responsible, including and deductibles, copayments, coinsurance or other fees required by insurer, HMO, or other health benefit plan. I understand that it is my responsibility to obtain any pre-certifications that are required for treatment or services to be provided by the Hospital and that failure to do so may result in denials and reduction of benefits from my insurance company. I further understand that if I have not provided the Hospital with accurate and current information regarding my insurer, HMO or other health benefit plan, (e.g. Medicare or Medicaid), which provides me with health care coverage, I will be personally responsible for the cost of all care rendered to me by the Hospital and its physicians. All bills are to be paid when presented. In the event I fail to pay such bill, I agree to pay, in addition to the amount of the bill, any reasonable attorney's fees the hospital incurs in collecting the bill.
8. **Mental Health Outpatient Bill of Rights:** I agree that I have received a copy of the Mental Health Outpatient Bill of Rights.
9. **Notice of Privacy Practices:** I agree that I have received a copy of the Hospital's Notice of Privacy Practices.
10. **Children's Car Seat Information:** It is a law in New Jersey that a child under the age of 8 or 80 pounds must be secured with a child passenger restraint system that complies with federal motor vehicle standards in the rear seat. Children under 8 years who weight more than 80 pounds and passengers 8 to 18 years of age (regardless of weight) must ride properly secured in a seat belt. It is the responsibility of the parent/guardian to abide by the law. No child shall leave the hospital for discharge or other reasons unless secured in an appropriate child restraint system.

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11. **Authorization for Photographs/Video Tapes:** I do____ do not_____consent to the photographing/video taping/recording in any medium (collectively "Recording") of any procedure to be performed, including Recording of appropriate portions of the Patient's body; for the Hospital's internal purposes such as medical education. My consent is based upon the understanding that the Patient's identity will not be revealed to individuals outside of the Hospital by either pictures or other descriptive text accompanying the picture without obtaining further authorization from me.
12. **Personal Belongings:** I acknowledge that Children's Specialized Hospital is not responsible for lost or stolen items including but no limited to video games, cell phones, and music players.
13. I, the undersigned, being the patient/parent/legal guardian: ___ do ___do not authorize the Medical Staff and or the Therapy staff of Children's Specialized Hospital to communicate with me via secure-email, of the above listed patient's Protected Health Information. I understand that the information may contain HIV/AIDS, Psychiatry Information, Psychology Information, Sexually Transmitted Disease Information, Tuberculosis or Genetic Information.

I understand that this Consent/Agreement is specific to Mental Health services provided to patients by the Hospital. I understand that this form must be completed at Registration, one time only and on an annual basis.

I confirm that I have read and fully understand this form, and that all the blank spaces have been completed or crossed off prior to my signing. I have been given an opportunity to ask questions and all of my questions have been answered fully and to my satisfaction.

(Signature of Patient/Parent/Legal representative)

(Date Signed)

(Relationship to Patient)

(Signature of Witness)

(Date Signed)