Children's Specialized Hospital
An RWJBarnabas Health facility

CHILDREN'S-SPECIALIZED HOSPITAL
CONSENTS/AGREEMENTS

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 assurances have been made to me concerning the patient's treatment by the Hospital which would require more treatment than 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. **Release of Information**: I authorize the Hospital to release the Patient's personal health information; **inclusive of AIDS, HIV, Psychiatric/ Psychotherapy, Drug/Alcohol, Behavioral Health, Mental Health, and Congenital Conditions:** (a) to any requesting health care provider for further diagnosis, care or treatment or for that provider's payment or health care operations purposes; (b) to any person or entity which may be responsible for billing and/or collection of claims for medical services or products provided by the Hospital under an insurance or other contract or obligation; (c) to any person or entity which is or may be liable under an insurance or governmental agencies' other contract or obligation to the Hospital or the Patient (or the Patient's family) for all or part of the Hospital's charges or staff or physicians' charges, including, but not limited to, insurance companies, health maintenance organizations, workers' compensation carriers, or other third party payors (e.g., Medicaid, Medicare or Blue Cross); (d) to any governmental agency or other organization responsible for oversight of the Hospital or third party payor; or (e) for the Hospital's normal health care operations. In the event that the Patient is to be considered for placement in an alternate care facility, I hereby authorize the Hospital to release the Patient's medical record to such facility for the purpose of discharge planning and/or continuation of post hospital care.

6. **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).**

7. **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

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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.

8. **Medicaid**: I authorize to release to the Board of Social Services and authorized agents any medical or other information needed to facilitate my application for benefits and to process this claim. I request that payment of authorized benefits be made on my behalf

9. **Medicare/Signature on File**: I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to the Patient in the Hospital, including physician services. I authorize any holder of medical or other information about the Patient to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits for related services. I have received `an important message from Medicare' from the Hospital on the date listed below. This does not waive any of my rights to request a review or make me liable for any Medicare payments for which I would otherwise be liable.

10. **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 any 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.

11. **Patient Bill of Rights**: I agree that I have received a copy of the Patient Bill of Rights.

12. **Notice of Privacy Practices**: I agree that I have received a copy of the Hospital's Notice of Privacy Practices.

13. **Authorization for Trips**: I do ___ do not ___ grant permission for the patient's participation, based on medical approval in community re-entry/recreational trips as deemed appropriate by the Medical staff .

14. **Authorization for Transportation:** I hereby authorize the Hospital to transport the Patient for any necessary services that the Hospital does not perform and for hospitalization elsewhere, if required.

15. **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 weigh 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.

16. **Authorization for Pet Therapy:** I do ___ do not ___ grant permission for the Patient to participate in the dog visitation program at the Hospital. I understand that the visiting dogs have been certified through a pet therapy organization. Records of current vaccinations and licenses are maintained by the Hospital and the pet therapy organization they are certified through. To my knowledge, my child is not allergic to or afraid of dogs.

17. **Authorization for Photographs/Video Tapes:**
I do ___ do not___ consent to the photographing of the Patient for identification purposes, this photo will be maintained in the patient's electronic medical record.

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I do ___ do not___ I 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.

18. **Personal Belongings:** I acknowledge that Children's Specialized Hospital is not responsible for lost or stolen items including but not limited to video games, cell phones, and music players.

19. I, the undersigned, being the patient/parent/legal guardian, do ____ do not ____ authorize the Medical staff and the Therapy staff of Children's Specialized Hospital to use confidential, secure e-mail for communication 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 all services provided to patients by the Hospital. This Consent/Agreement applies to any and all services provided during the course of Inpatient/Long Term Care Stay. I understand that for Inpatient/Long Term Care Stay Patients, this form is to be completed at the time of Admission and will apply to any and all treatment during that stay. I understand that for Out Patient Services, this form must be completed at Registration, one time only and on an annual basis. A new Consent/Agreement must be completed January of each new year.

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)