



Parent / Guardian's Consent for Treatment, Information Sharing, and Financial Agreement

Patient name: _____

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 the patient's health information to referring physicians, specialists, or other providers who may be involved in the patient's treatment. I understand that ETCH may exchange this health information electronically through the East TN Health Information Network (eHIN). I understand I can choose not to participate by completing the eHIN Exchange Opt-Out Form.
3. I understand that the patient's insurance company needs to know about the patient's visit. I allow ETCH to give necessary medical information to the patient's insurance company, any government agency, or the State of Tennessee.
4. I DO DO NOT give ETCH permission to request the patient's Medication History from other providers and from the patient's 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 the patient may receive treatment from a health care provider who is not listed in the patient's insurance plan. I understand that I may receive a separate bill for the health care provider for the amount not paid by the patient's insurance.
7. I will pay the deductible and/or co-payment amounts and will pay for charges not covered by the patient's 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 the patient's insurance plan requires a referral from the primary care physician, the referral must be obtained before the visit to ensure the patient's 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 the patient is 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 the patient must come to all scheduled appointments. I understand that if the patient misses multiple appointments, the patient may be discharged from the practice.
11. I understand that a provider or employee may be exposed to the patient's blood. If that happens, I allow ETCH to test the patient's 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 understand that it is this office's policy to retain a scanned copy of legal documents or guardianship papers if guardianship changes at any time. I understand that the office requires a copy of identification the first time someone presents with a patient. Insurance cards may be requested at each visit.
15. I give consent for the following individuals to bring the patient to ETCH for treatment of illnesses or injuries. I hereby give permission to ETCH to exchange information 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 ETCH

Signed: _____ Date: _____

Printed name: _____ Relationship to patient: _____

Interpreter's signature: _____ Date: _____

Witness signature: _____

Received via mail and requires no witness