Nemours® Children's Hospital

Patient Name: _____

MRN: _____

Consent Upon Admission and Release of Information for Payment and Treatment Purposes
Form# 01026

Patient: _____ MRN: _____
Last First M.I.

Admitting Diagnosis: _____ Date of Admission: _____

I authorize treatment for the above named patient by Nemours* health care practitioners under the supervision of the Attending Physician. My Attending Physician or his designated alternate has discussed and explained to me, in terms I understand, the diagnosis and proposed hospital course of treatment.

I understand that the planned hospital course may include the use of X-rays, laboratory tests, medications, physical therapy, occupational therapy, recreational activities, appropriate dental care, and other diagnostic procedures, tests, and therapy routinely provided in a pediatric teaching and research hospital. I understand and consent to Nemours making recordings (photographs, video, electronic or audio media) of my child for identification, diagnosis and treatment purposes and that these recordings may also be:

- Used within Nemours for performance improvement, medical education, and other purposes related to healthcare operations provided my child's identity is revealed only when necessary to complete the task.
- Disclosed to individuals external to Nemours only if my child's identity has been completely removed from the recording, or if Nemours has a written authorization from me, my child's legal representative, or my child upon reaching the age of majority (adulthood).

I consent to the transfer to another hospital or treatment center if such transfer has been deemed necessary or advisable for specific tests or treatments. I understand that in the course of treatment and in obtaining payment for treatment, Nemours may have to share with insurance companies and other providers medical information regarding the above named patient's treatment or condition. I consent to the sharing of such information for treatment and payment purposes.

Assignment of Benefits and Financial Responsibility

I hereby authorize payment directly to the Alfred I. duPont Hospital for Children of the Nemours Foundation/Nemours Children's Clinic of hospitalization/medical benefits not exceeding the hospitals/Physician's regular charges, otherwise payable to me. I realize that I will be ultimately responsible for the financial charges incurred. I certify that I am the party legally responsible for the patient named above.

I authorize Nemours duPont Hospital for Children to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided.

_____ _____
Witness Patient or Person Legally Responsible for the Patient

_____ _____ a.m. p.m. _____ _____ a.m. p.m.
Date Time Date Time

Receipt of Nemours' Notice of Privacy Practices (New patient or patient turning 18)

Nemours is required by the Health Insurance Portability and Accountability Act of 1996 to provide each patient and his/her legal representative a copy of our Notice of Privacy Practices. We are also required to obtain a signed acknowledgement from each patient's parent or legal representative indicating that they have received this Notice. We appreciate your cooperation in signing below to fulfill this requirement.

I, _____ , acknowledge receipt of the Nemours Privacy Practices on behalf of _____
Print Your Name Print the Patient's Name

_____ _____
Signature Date

(To Be Completed Only When Appropriate)

I, _____, certify that I am fluent in the native language of the person indicating consent in the above form. I certify that I have accurately and completely translated the consents of this form, and that the patient and or adult legally responsible for the patient indicated their understanding of the contents of this form.

_____ _____ a.m. p.m. _____
Date Time Translator's Signature

*Nemours includes The Nemours Foundation, its operating divisions and sites, and its affiliates and subsidiaries.