Children's National

Children's National Hospital
Mobile Health Registration Form

Are you a new patient? Yes or No
(Have you been seen at a Children's National Hospital facility in the District of Columbia?)

Patient Name: _____

Patient DOB: _____ Sex: _____

Address: _____

_____

Phone Number: _____

Parent/Guardian Name: _____

Parent/Guardian Date of Birth: _____ Sex: _____

Parent/Guardian Phone Number: _____

Insurance Name: _____

Insurance ID: _____Group #: _____

Parent/Guardian Email Address: _____

Patient Race: _____ Patient Ethnicity: _____

Primary Language: _____

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Revised Version of Consent as of October 2024

OUTPATIENT SERVICES CONSENT FOR PROCEDURES AND TREATMENT

Section #1

I understand that Children's National Medical Center (Children's National) needs me to sign a consent. I understand I need to sign it before my child or myself as a patient 18 years of age and older can be examined or treated. I give consent to Children's National and its employees and/or contractors including agency nurses, physicians, and staff who are non-hospital employees (contractors) to examine and treat this patient by signing this paper.

I, _____ give consent to Children's National, its employees and/or contractors, including non-Children's National agency nurses, physicians, and staff, to examine and treat _____.

I understand that:

- Tests and immunizations may be included.
- I may need to give a separate written consent for some treatments and procedures.
- **I can cancel this consent in writing and/or limit release of medical records. If I notify Children's National in writing to cancel this consent, Children's National may no longer examine and treat the patient.**
- There are no guarantees for outcomes and results.

This Consent for Treatment is valid for one year from the signature date below for all outpatient service clinic visits.

Section #2

TEACHING, TRAINING AND EDUCATION

I understand that trainees, including, but not limited to, residents, fellows, nurse practitioners and physician's assistants, may perform important parts of the care my child/I may receive. Each trainee will have an appropriate skill set to perform the care being provided and will be under the supervision of the primary provider. I understand that the names of trainees, and the tasks they perform, will be documented in the medical record.

EDUCATION, PUBLICATIONS, MARKETING AND FUNDRAISING

I agree that Children's National may use unidentifiable patient medical information, statements, artwork, videos or pictures. As long as the patient cannot be identified, these items may be used for teaching purposes, educational/medical publications, marketing and fundraising. If identifiable information or a patient's likeness is used in any public capacity, Children's National will seek additional authorization from the patient's guardian.

SPECIMENS AND BLOOD TESTING

I understand that some blood, tissues and other samples taken for tests or procedures may be left over after the test or procedure is finished. I agree that these items may be used for teaching, research or in medical chart review if the patient cannot be identified. These uses must first be approved by an Institutional Review Board and are not covered by U.S. law on human research. I understand that a health care provider may accidentally come into contact with the patient's blood or body fluids. If this happens, I consent to testing the patient for infectious diseases including HIV. I agree that the exposed person may be given the results. I understand that the law may require Children's National to report some medical outcomes to the government.

OBSERVATION AND MONITORING

I understand that Children's National may use video or other recording devices for treatment, teaching, monitoring of the condition, progress, and safety of the patient, or other clinical purposes including quality improvement related to Children's National's services. Photographs created for these purposes will not identify the patient by name. This does not include photographs for publicity which involve signature of a separate consent and release form.

Section #3

TELEMEDICINE

I am consenting to Telemedicine Consultation and/or treatment with the Children's Hospital. I understand that as a participating patient, my physician and I will communicate by interactive television (videoconferencing) with physicians, mental health providers, and health care professionals at Children's Hospital. I understand that medicine is not an exact science and there are no guarantees that can be made regarding outcomes and results of these examinations and treatments. I also understand, Children's Hospital will submit bills for any related Telemedicine Services to my insurance carrier; any non-covered services will be billed to me directly.

I understand that I have the right to withdraw my consent at any time. I understand that either the healthcare provider or I can discontinue my child's telemedicine health visit if it is felt that the videoconferencing connections are not adequate for the situation.

I understand it may be necessary for others to be present during the visit other than my child's healthcare team and provider. These individuals are bound to maintain confidentiality of all information obtained. I further understand that I have the right to request the following when other individuals, including nonmedical and medical personnel, are present: (1) omit specific details of my child's medical history/physical examination that are personally sensitive to me; (2) ask such individuals to leave the examination room; and/or (3) terminate the visit at any time.

I understand that the responsibility of the telemedicine healthcare provider concludes upon the termination of the video conference connection, and Children's National is not responsible for the distant site's actions.

I understand that any identifiable member image or other information from the Telemedicine Service will be used for medical purposes and maintained by Children's National as confidential medical records, consistent with Federal and State law. I also understand that I have the right to object to videotaping during the visit.

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Section #4

PARENTAL ACCESS TO INFORMATION, VISITATION, DISCLOSURE (For Patients Under 18 Years Old)

I understand that either parent may see the medical record, visit the patient, take the patient home, or make care decisions. If a court has limited either parent's rights, I agree to give Children's the court paper stating so. I agree to give Children's National the names of any other people who I want to get information about my child. I agree to tell Children's National how to reach me such as by phone, cell phone, fax, mail, or e-mail. By providing Children's National with my cell phone and or landline phone, I agree to be contacted via text message, voice and/or recorded call by Children's National or its contracted business associates for all healthcare calls to include: appointment reminders, pre-registration instructions, prescription notifications, accounting, billing, or debt collection.

I understand that Children's National follows all federal and local laws including the Health Insurance Portability and Accountability Act. I understand that this Consent allows Children's National to use private health information for treatment, payment and hospital operations as defined in the Notice of Privacy Practices. I agree that Children's National may use de-identified health information about my child for approved research and quality improvement activities.

I understand that if my child is enrolled in my local public or private school system, limited information about my child's admission may be shared with the local school nurse in order to ensure continuity of care after my child's discharge.

Health data pertaining to you or your child is shared between authorized health care providers within our health information exchange Chesapeake Regional Information System for our Patients (CRISP) and larger scale health exchanges- Commonwell / Carequality to ensure that accurate and complete information is available to make your care or the care of your child safer, more efficient, and less costly. The Children's National Hospital's health exchange and CRISP connects Children's National hospital with regional emergency departments, community health centers, independent health care practitioners, regional immunization registries and commercial laboratories.

*You may **opt out** of Children's National Hospital's health exchange and Commonwell/Carequality and disable access of your child's health information available through the HIE. Please notify a front desk registration representative to complete the opt-out process. While you may opt out of these networks, health information that has been received or accessed via the HIE prior to such opt out and incorporated into a health record may be retained by that provider.*

*You may **opt out** of CRISP and disable access of your health information available through CRISP by contacting CRISP at 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax, or through their website at crisphealth.org. Even if you opt-out of CIQN and CRISP, state public health reporting and controlled substances reporting information, such as the Maryland Prescription Drug Program (PDMP) will still be available to providers as required and permitted by law.*

Section #5

PAYMENT, INSURANCE, AND ASSIGNMENT OF BENEFITS AUTHORIZATION

I assign to Children's National the right to bill and collect from any insurance that covers the patient. I agree to help Children's National seek payment and to tell the Children's National about any resources for payment of the patient's bill. I will pay any deductible, co-payment, and any amounts denied or not covered by insurance. If the patient is uninsured, I will apply for medical assistance programs including but not limited to Medicaid. If the patient is uninsured and is not eligible for a medical assistance program, I agree to give financial information to Children's National to see if I am eligible for reduced charges or charity funds.

I understand that there may be professional fees associated with the patient's care and that those fees will be billed separately by the persons or organizations that provided the services. I assign the right to bill and collect from any insurance that covers the patient to any physicians, caregivers, or other providers of services who are not employed by Children's National and whose services will be billed separately for all treatment provided.

I consent to use and disclosure by Children's National and/or the patient's care providers of portions of the patient's Record, including medical records (including psychiatric, drug and alcohol abuse information, genetic testing information, and the results of specific laboratory tests, which may include HIV or AIDS diagnosis), to any person or entity that is or may be responsible for all or any portion of Children's National's and/or providers' charges, including but not limited to insurance companies, health care service plans, worker's compensation carriers, medical or utilization review organizations of the foregoing or to any other person or entity as necessary in connection with such payments or reimbursement.

I also agree that Children's National and/or the patient's provider may obtain from any source and examine and use, or discuss and disclose, the patient's medical record information (including medical history, examinations, diagnoses, treatments, any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information) to treating Children's national personnel and agents, other health care providers, medical records auditors, professional care committees, evaluators and governmental agencies in order to treat the patient or for Children's National to carry out its operational duties.

I understand that I am responsible for providing Children's National proof of insurance and referral/authorization; and operating within my insurance company's guidelines. I understand that if I do not do so, my insurance may apply the services to my lowest level (out-of-network , e.g., Preferred, POS Choice, Select, etc.) benefit. My 'out of pocket' financial responsibility may be greater as a result, and I am personally responsible for making full payment for all charges resulting from this consent for services. I may request an estimate of cost if I utilize my out-of-network benefits.

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Section #6

PATIENT IDENTITY

By signing this document I have given truthful information about the patient's name and identity. It also means that I understand how important it is to provide truthful and accurate information about the patient's name and identity. I understand that incorrect or false information about identity can lead to treatment that could be harmful to the patient. I understand that Children's National reserves the right to take action for intentional presentation of false information including transfer of care and appropriate reporting to authorities.

Section #7

DISCHARGE

I understand that Children's National is an acute care facility and that once the patient is medically able, he/she will be discharged to home or to a non- acute care facility. I consent to a transfer or discharge once the attending physician determines that it is medically appropriate. If I do not take the patient home after the patient is discharged to home, I agree to pay Children's National's full inpatient charges for additional days and services. I will provide the specific names of any persons other than the parents/legal guardian who are authorized to take the patient home when discharged from inpatient or outpatient care.

THE PATIENT MAY ALSO BE DISCHARGED TO (Optional):

Name (please print)	Relationship to Patient	Phone Number

Name (please print)	Relationship to Patient	Phone Number

PATIENT RIGHTS (parent or adult patient to check mark below)

☐ I have been given information about Patient Rights and the Notice of Patient Privacy Practices at Children's National in a language that I understand. I know who to contact with questions or concerns or to file a complaint.

SPECIAL BILLING CIRCUMSTANCES

☐ I voluntarily request that Children's National **NOT** bill any insurance the I/patient may have, without regard to whether these services are covered by any such insurance

ADVANCE DIRECTIVES: FOR PATIENTS over 18 years of age. An advance directive, also known as a living will, is a legal document in which an adult patient specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity. Booklets are available to patients over 18 years of age. **If you are over 18 and you would like an advance directive, alert a clinical staff member (doctor, nurse or social worker).**

If you have an advance directive, check the box below and provide a copy to your clinical team.

☐ Yes, I have an Advance Directive.

SIGNATURES

By signing this consent, I acknowledge that I have read sections #1 through #7 and in agreement with the content within.

Signature of Parent/ Legal Guardian/ Patient 18 years of age or older

Today's Date : ____/____/____
MM DD YY

Print Name	Relationship to Patient	Phone Number

OPSC

Children's National.

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CHILDREN'S NATIONAL STAFF ONLY

Special Consent Circumstances (when applicable):

☐ **The above was reviewed with the consenting person in _____(language), using an interpreter:**

☐ **In person** ☐ **Over the Phone** ☐ **Video Remote** ***(If by Phone or Video, please write Interpreter ID # in Signature field below)***

Signature of Interpreter _____ **Print Name**_____ **Date:** ___/___/____
MM DD YY

☐ **Consenting party is physically unable to complete a signature and has made their mark above on the signature line as witnessed by:**

Print Name of CN Employee_____ **Signature of CN Employee**_____

Phone consent when parent or legal guardian is not present:

1st attempt: **Special Consent Circumstances (when applicable):** ☐ **The above was reviewed with the consenting person over the phone.**

Name/phone number of person called for consent _____ **Relationship to Patient:**_____

_____Agreed to consent for treatment Date ___/___/____Time _____
MM DD YY

_____Unable to reach Date ___/___/____Time _____
MM DD YY

_____Message left Date ___/___/____Time _____
MM DD YY

2nd attempt: **Special Consent Circumstances (when applicable):** ☐ **The above was reviewed with the consenting person over the phone.**

Name/phone number of person called for consent _____**Relationship to Patient:**_____

_____Agreed to consent for treatment Date ___/___/____Time _____
MM DD YY

_____Unable to reach Date ___/___/____Time _____
MM DD YY

_____Message left Date ___/___/____Time _____
MM DD YY

PHONE CONSENT SIGNATURES: *If at the time of verbal phone consent, the parent/legal guardian has any clinical questions, the general consent must be signed by clinical staff members.

☐ **Clinical Staff Member-** By signing below, we (CN staff) attest that we have reviewed the general consent and informed the parent/legal guardian of the nature of the services as determined by the clinical team and answered any associated clinical questions.

☐ **Non-Clinical Staff Member-** By signing below, we (CN staff) attest that we have reviewed the general consent and informed the parent/legal guardian of the nature of the services as determined by the clinical team and the parent/legal guardian has no further questions.

_____ Date: ___/___/____ Time: _____
Print Name of CN Staff Obtaining Consent by Phone MM DD YY

_____ Date: ___/___/____Time: _____
Print Name of CN Staff Obtaining Consent by Phone MM DD YY

OPSC

Authorization for Release of Medical Information

Health Information Management
Mon – Fri 8:30am to 5:00pm
111 Michigan Avenue, NW
Washington, DC 20010
Phone (202) 476-5267
Fax (202) 476-2270
medicalrecords@childrensnational.org

Select Location(s) for Request:

- ☐ Childrens National Hospital
- ☐ Childrens National Pediatrics & Associates
- ☐ Hospital for Sick Children
- ☐ Dentistry***

Medical Record # *(Office Use Only)*

Patient Name | Date of Birth | Phone Number

Street Address | City, State, Zip Code

(1) I, the undersigned, hereby authorize Children's National Medical Center to use and/or disclosure the above-named individual's health information to:

Name of Person and/or Agency | Phone Number

Street Address | City, State, Zip Code

(2) Provide the records by means of:

- ☐ Mail
- ☐ Secure E-Mail _____
- ☐ CD
- ☐ Pick-Up
- ☐ Fax *(Immediate Patient Care Only)* _____

(3) Date of Service (specify date range): _____ to _____ and for the purpose of:

- ☐ Continued Medical Care
- ☐ School
- ☐ Self
- ☐ Other: _____

(4) Release the following information (check all applicable information to be released):

- ☐ Abstract/ Summary
- ☐ Immunization Record
- ☐ Well Child
- ☐ Physicals/School Form
- ☐ Emergency Room Record
- ☐ Inpatient
- ☐ Outpatient Report
- ☐ History and Physical Report
- ☐ Discharge Summary Report
- ☐ Laboratory Report
- ☐ Radiology Report
- ☐ Radiology Images***
- ☐ Clinic Report
- ☐ Child & Adolescent Protective Center ***(Requires dept. approval)***
- ☐ Psychiatric Treatment Records, Psychotherapy notes ***(Requires dept. approval)***
- ☐ All Records
- ☐ All Records ***(excluding Psychiatric Treatement records, Psychotheraphy notes)***

*****For Radiology films/images, please call (202) 476-3426**
*****For Dental Records, please call (202) 476-2160**

(5) I understand the above- named individual's health information may include information relating to sexually transmitted diseases, genetics, sexual activity including contraceptive methods, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) where applicable. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse in accordance to 42 CFR Part 2.

(6) I understand that I have the right to revoke this authorization at any time. If I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to process a claim under my policy. **This authorization will expire within six months** unless otherwise revoked for the following date, event, or condition: _____.

(7) I understand that authorizing the disclosure of this health information is voluntary. I understand that there are fees associated with re-disclosures excluding for direct patient care (i.e., practitioner to practitioner communication). I understand that I may inspect the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosures, and the information may not be protected by federal confidentiality rules.

(8) **PSYCHIATRIC TREATMENT: This authorization does not apply to any mental health information obtained after the signed date of the authorization below. The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosure may be made pursuant to a valid authorization by the client or as provided in Title III or IV of the Act. The Act provides for civil damages and criminal penalties for violation.

(9) I, do hereby, declare that I am the patient/parent/legal guardian and am responsible for the release of information with regard to the above- named patient. (Appropriate documentation will need to be provided with authorization in order to process release). **NOTE: If patient is of legal age (18), patient will need to sign the release themselves.**

Print Name of Parent or Legal Guardian | Date

Signature of Patient

Signature of Parent or Legal Guardian | Witness

MEDREC7

REV05/2003, 06/2014, 10/2017,8/2018, 11/2019, 7/2020, 9/2020,2/2022,9/2022,6/2023

Children's National

PATIENT BARCODE LABEL

AUTHORIZATION TO CONSENT

1. _____I am the parent of the child(ren) listed below and there are no court orders now in effect which would prohibit me from exercising the power that I now seek to convey;

OR

_____I am the legal guardian or custodian of the child(ren) by court order (copy attached, if available) and there are no other court orders now in effect which would prohibit me from exercising the power that I now seek to convey.

2. _____I am temporarily entrusting to _____, an adult who resides at_____, the care of the following child(ren):

Name	Date of Birth	Name	Date of Birth
Name	Date of Birth	Name	Date of Birth

3. The caregiver named above may consent to medical, dental, surgical and/or mental health diagnosis and treatment for the child(ren).

4. I am giving this consent freely and knowingly in order to provide for the child(ren) and not due to pressure, threats, or payments by any person or agency.

5. This authorization will be effective for 90 days from the date of signature.

I hereby swear or affirm that the above statements are true, under penalty of law.

Name Date

TACT

Family Resource Screener

For all ages

Children's National

We want your family to be healthy and safe, and to have access to available resources in your community. We are asking everyone to answer the following questions. Please check all that apply.

Parent/Caregiver's Name: _____ **Phone:** _____

Email: _____ **Zip Code:** _____ **Call** ☐ **Email** ☐

Child's Name: _____ **Child's DOB:** _____ **Language:** _____

Today's Date: _____ **CHECK ALL THAT APPLY.**

	I would like to get help with providing **food** for my family	☐
	I have trouble paying my **utility** bills (gas, electricity, water, or phone)	☐
	I need help finding **a job, job training, employment programs,** or to get my **GED**	☐
	I want to apply for **public benefits** (Food Stamps, WIC, SSI/SSDI, Health Insurance)	☐
	My Family needs **daycare, diapers, baby supplies** or a **Cribette/Pack N Play**	☐
	I need help with **housing** Current living situation: _____	☐
	**Household issues, Landlord issues:** Circle all that apply**: (pests, dust, mold, lead paint, leaks, stove, refrigerator not working, heat not working, no smoke detectors,)**	☐
	I need **transportation** to medical appointments or help getting **medications**	☐
	**Does anyone, including family, hurt you?**	☐

☐ **CNH Primary Care Clinic** **- Clinic:** _____

Comments: _____

_____

Screener, Print Name: _____ Date: _____