Cincinnati Children's
changing the outcome together

Consent for Medical Treatment & Assignment of Benefits and Release of Information (Financial Responsibility)

Downtime Form

Name: _____

DOB: _____

MRN: _____

Person Authorized to Consent: To protect the rights and honor the wishes of our patients and their authorized representative(s), Cincinnati Children's Hospital Medical Center must be aware of the name, relationship and telephone number of the person authorizing consent. Except in emergency situations determined by our medical staff or when the patient is legally permitted to consent to his/her own treatment, the authorized representative must authorize hospitalization and any special procedures. Patients should be discharged only to an appropriate individual pursuant to the Medical Center Policy entitled Persons Authorized to Consent for Admission, Treatment and Discharge of Patients.

CONSENT FOR MEDICAL TREATMENT

For those patients being treated at Cincinnati Children's Hospital Medical Center (CCHMC), I authorize CCHMC and the doctor(s) participating in the care of my/our child to use any treatment or procedures that may be deemed necessary in the medical or dental care and that may be reasonably expected to be part of the normal inpatient or outpatient service. This shall include the use of drugs, medicines, laboratory procedures, X-ray procedures and diagnostic testing (whether performed at CCHMC or at nearby facilities), immunizations, preventive medicine procedures, routine recreational activities, and the use of local anesthesia during laboratory procedures and diagnostic testing. This consent for treatment does not authorize any type of surgical or medical procedure requiring the use of general anesthesia or sedation. I understand that during the diagnostic or treatment process, the medical team may determine that it is in the best interest of my child to refer him/her to other services within CCHMC. I authorize such transfer and treatment. This authorization shall allow the doctors to provide continuing services until revoked by me in writing. For patients receiving care in the shock/trauma suite, I authorize CCHMC and their physicians to take video/audio recordings of me/my child or part of my/my child's body while under the care of the hospital. These images can only be used for medical education or performance improvement. Images obtained for either purpose will be destroyed after 180 days. CCHMC may provide certain services utilizing telehealth technology, including transmission of images, video and audio that are encrypted for privacy. The remote provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription for myself/my child. I understand that I/my child may have to travel to see a health provider in-person for certain diagnosis and treatment or in the event of a technical failure.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION (FINANCIAL RESPONSIBILITY)

In consideration of services rendered, I authorize payment to Cincinnati Children's Hospital Medical Center for all hospital, physician/professional, and ancillary services rendered, and I assign to CCHMC all right, title, and interest in and to any third party benefits due from any and all insurance policies, employee benefit plans, and/or responsible third party payers in an amount not to exceed CCHMC's regular and customary charges for services rendered. I accept responsibility for determining whether services provided to me are covered by my insurance or other third-party payer, and I understand that I am responsible to CCHMC for charges not covered by my insurance company for services provided. If a referral from my insurance company is required for payment to be made, I assume responsibility for obtaining this referral and for all charges associated with this account if no referral is obtained. I consent to any request for review or appeal by CCHMC to challenge a determination of benefits made by a third-party payer, insurance carrier, or employee benefit plan.

I also authorize CCHMC and any treating physician to release any and all information related to the care and treatment of the patient that may be requested or required by the third party payer (insurance company, government agency or its respective agents, or employer), to the extent necessary to secure payment. I further authorize the release, to the extent necessary, of information from my child's medical record to appointees of the CCHMC medical staff, its allied health professionals, employees and other agents, as well as to accrediting and licensing/regulatory entities who have, in turn, agreed to keep such information confidential, for the purpose of reviewing or auditing the performance of CCHMC, its medical staff, its allied health professionals, its employees and/or agents otherwise assisting CCHMC in the rendering of medical care or the performance of other health care operations. Patient information may be stored electronically and used to improve clinical outcomes. This authorization includes the release of information concerning HIV testing, diagnosis or treatment of AIDS, AIDS-related conditions, drug/alcohol abuse, drug-related conditions, and/or psychiatric/psychological diagnosis and treatment.

TIME: DATE:

Signature of Patient/Parent/Person Authorized to Consent | Print name of Patient/Parent/Person Authorized to Consent

TIME: DATE:

Signature of Witness/Credentials | Print name of witness

_____ Via: ☐ Phone ☐ Video ☐ On-site

Print name of interpreter and ID number *Note: The interpreter cannot sign as the witness above*

☐ Unable to obtain written consent; see Verbal Consent/Authorization for Admission/Treatment Form