Packard Children's Health Alliance

Medical Network of
Lucile Packard Children's Hospital

Conditions of Registration

Authorized Signature

You may sign this form only if you are a competent adult over the age of 18 or a minor who is permitted under state law to consent to treatment. Alternatively, the form must be signed by a properly designated representative, such as a parent or legal guardian. You will be asked to sign this agreement annually. At each clinic visit, you will be asked to confirm that your demographic and insurance information is correct. If your insurance or demographic information has changed, please inform the clinic staff.

Medical Consent

I, the undersigned, consent to the general treatment and procedures that may be performed during the patient's clinic visit. These procedures may include but are not limited to laboratory procedures, x-ray examinations, medical photography, medical or surgical treatment and procedures deemed necessary and performed by and under special instructions of the patient's physician. I understand that it is the responsibility of the patient's physician to obtain further informed consent to treat when required for specific medical or surgical treatment and procedures, anesthesia and special diagnostic or therapeutic procedures. I understand and agree that at the request of the attending physician, allied health practitioners (such as physician assistants and nurse practitioners) may participate in the patient's care.

Teaching Institution

PCHA is affiliated with the Stanford University School of Medicine ("Stanford") and Lucile Salter Packard Children's Hospital at Stanford ("LPCH") which train medical students, physicians, surgeons, nurses and other health care personnel. At the request, and under the supervision, of the patient's physician, I agree that residents, interns, medical students, post-graduate fellows, and other health care personnel in training may participate in the care of the patient.

☐ I agree ☐ I disagree

Financial Agreement

I accept full financial responsibility and agree to promptly pay all PCHA bills in accordance with the regular rates and terms of PCHA, including charity care and discount policies, if applicable. This includes financial responsibility for all deductibles and copayments that may be required by the patient's insurance or health plan, including Medicare and Medi-cal. I will pay actual attorney's fees and lawsuit-related expenses incurred in addition to other amounts due should the patient's account(s) be referred to an attorney or a collection agency for collection.

☐ I agree

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Assignment of Insurance Benefits (including Medicare Benefits)

I assign and authorize direct payment to PCHA dba LPCH Medical Group of any insurance benefits payable for these outpatient services. I agree that the insurance company's payment to PCHA dba LPCH Medical Group pursuant to this authorization shall discharge the insurance company's obligations to the extent of such payment. I understand that I remain financially responsible for charges not paid according to this assignment. If applicable, I attest that information given to PCHA to assist the patient in applying for payment under the Medicare or Medi-cal programs is correct.

Contracted Health Plan Patients and Other Sources

I understand that the patient may be eligible for certain health care coverage through a health plan (HMO, PPO) on the list of health plans with which PCHA dba LPCH Medical Group contracts or through some other source. I agree to be responsible for paying the patient's account: (a) if PCHA dba LPCH Medical Group does not contract with the health plan; (b) for any copayment and deductible; (c) for services not approved by the health plan or other source; or (d) for services not covered and/or paid for by the patient's health plan or other source.

Signatures

I confirm that I have read the preceding information and received a copy of it. My questions have been answered fully and to my satisfaction. I am the patient, the patient's legal custodial parent, legal representative, or am otherwise authorized by the patient to accept the above terms on the patient's behalf.

_____ _____ _____AM / PM

Print Name Signature Date/Time

Indicate Relationship to Patient:

☐ Self

☐ Parent with Legal Custody (not to be confused with physical custody)

☐ Legal Guardian. Type of Guardianship_____

☐ **Documentation Received *(for office use only)***

☐ Authorized Representative. Explain Basis for Authorization_____

☐ **Documentation Received *(for office use only)***

Clinic Staff Signatory Witness:

_____/_____

Print & sign name (*Required for patient telephone consent, physical inability to sign, or signature by mark)*

If Interpreted:

_____ _____ _____

Interpreter Signature Print Name Language