Children's Mercy

Informed Consent for Medical or Dental Treatment

(Front)

8071-051 MR 01/17 (Translated 01/17)

I hereby authorize, for the patient named below, examination and treatment by members of the medical staff of The Children's Mercy Hospital (CMH), residents, and any assistants or designees deemed necessary by the physician, practitioner or dentist. I realize that among those who provide patient care at CMH are medical, dental, nursing, allied professionals, and other health care personnel in training who may be participating in patient care as a part of their education. I also understand that some physicians providing my services are not agents or employees of the facility, but are independent physicians who have been granted the privilege of using its facilities for the care and treatment of patients. I hereby authorize the collection of medication history from regional and national databases for the purpose of providing patient care. I am aware that the practice of medicine, dentistry, and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments or examination at CMH. I hereby authorize the pathologist or other designated personnel to dispose of, or use for internal or external quality control and test validation, in accordance with established policy, any tissue or specimens resulting from a procedure.

PHOTOGRAPHS AND VIDEOTAPING

I authorize the closed circuit monitoring, photographing, and videotaping of this patient, and the confidential use of the resulting images and data, for medical and teaching purposes.

AUDIOVISUAL ENCOUNTERS

I authorize the use of secure interactive video communications and the secure electronic transmission of information between this patient and CMH staff. An audiovisual encounter is the exchange of information between CMH staff caring for a CMH inpatient or outpatient while onsite at CMH and a family member or caregiver who is authorized to receive such information by audiovisual means in another location.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I hereby assign benefits and authorize payment, directly to CMH and the practitioners providing care, any and all benefits from any third party medical insurance coverage, including but not limited to Medicare and Medicaid benefits, for services provided. I certify that the information I have given to CMH is correct and complete. Furthermore, I authorize the release of any information needed to determine my benefits or secure payments. I understand that CMH bills as either an outpatient or inpatient hospital. I understand that Children's Mercy Hospitals and Clinics will bill all outpatient services as specialty outpatient hospital services. I understand that I am financially responsible for any and all charges incurred for services that are provided and not covered by insurance and I agree to promptly pay CMH and the practitioners providing care. In the event of non-payment, the Hospital reserves the right to make inquiries of outside sources, such as credit agencies, to obtain information with regard to household size, income, and credit scores for the Responsible Party.

Primary Care Physician: _____

Patient's Name: _____

Date of Birth (month/day/year): _____ Phone Number: _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Signature of Patient or Legal Guardian: _____

Printed name of Patient or Legal Guardian: _____

Relationship to Patient: _____ Today's Date (month/day/year): _____ Time: _____

TELEPHONE AND INTERPRETER CONSENT: **STAFF USE ONLY**

I read the above statement to _____, reached at (___)___-____ on ____/____/____ at _____ hours; he/she stated understanding and approval.

_____ ____/____/____

Signature of 1st Witness — Printed Name — Date

_____ ____/____/____

Signature of 2nd Witness — Printed Name — Date

_____ ____/____/____

Interpreter's Signature — Printed Name — Date