22045-01

Children's Healthcare of Atlanta
at Hughes Spalding

RONALD McDONALD CARE MOBILE® CONSENT TO TREAT

The Ronald McDonald Care Mobile's mission is to bring asthma care where kids live, learn, and play.

Name _____

Date of Birth _____

MRN# _____

Account/HAR# _____

PATIENT IDENTIFICATION

School Attending: _____

I. CONSENT FOR TREATMENT: I hereby authorize and voluntarily consent to the Ronald McDonald Care Mobile® (Care Mobile) school based medical clinic, which is staffed by state-licensed professionals of Children's Healthcare of Atlanta at Hughes Spalding (Hughes Spalding) providing the patient with basic treatments and medical and diagnostic procedures, including diagnosis of acute and chronic illness and disease and prescribing medications in person or via video conferencing technology (Telemedicine). I understand that the treatment may include routine diagnostic testing, including additional laboratory testing at a later date on specimens collected, based on initial results, labs resulting from infection control or public health investigations, x-ray examinations, and communicable disease screening (for diseases such as Chicken Pox, Hepatitis B, and German Measles). I understand that Hughes Spalding has physician's assistants, nurse practitioners, medical students, interns, residents and fellows who may participate in the care of the patient under the supervision of the attending physician. I further understand that additional clinical students may participate in the care of the patient. I hereby consent to their participation in the care and treatment of the patient.

II. AGENCY: Some or all of the healthcare professionals performing services at Hughes Spalding are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and Hughes Spalding shall not be liable for the acts or omissions of any such independent contractor.

III. TELEMEDICINE: I understand that some parts of a Telemedicine exam (if applicable) may involve physical tests conducted by the individuals at my/my child's location at the direction of the telemedicine consulting health care provider. I understand that video conferencing will not be the same as a direct patient care visit due to the fact that I/my child will not be in the same room as the health care provider. I understand the potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue my/my child's telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation. I understand that the school health staff or the Care Mobile staff will notify me prior to my child's encounter with the medical provider, including potential Telemedicine visits. I hereby give my permission for my child to receive care at the Care Mobile school based medical clinic whether or not I can accompany my child to the medical clinic each time.

IV. PERSONAL BELONGINGS: It is understood and agreed that Hughes Spalding shall not be responsible or liable for any loss, theft, misplacement or damage of any valuables and personal belongings.

V. DISCLOSURE OF INFORMATION: I authorize the Care Mobile school based medical clinic staff to disclose all or any portion of my child's medical record to persons or entities pertinent to his/her health care, including but not limited to his/her primary care physician, the school nurse and the Care Mobile staff. I further understand that all information in my child's medical record is confidential and will not be released to any unauthorized person or agency without written consent. I give consent to release any information regarding treatment to third party payers (insurance) for the purpose of billing.

VI. EMERGENCY SERVICES: I authorize staff to summon emergency services (9-1-1) for my child if necessary. Expenses related to ambulance or other emergency referral will be my responsibility.

VII. COMMUNICATION: I will attempt to make myself available for communication regarding my child's health needs. I understand that there are certain hazards and risks connected with all forms of treatment and consent is given in light of this knowledge. I understand it is my duty to inform the Care Mobile staff of any change in the child's guardianship.

PHOTOGRAPHS AND VIDEOTAPING: I understand that photographs, videotapes, digital, or other images may be recorded to document the patient's care and for internal quality reviews and I consent to this. I understand that Hughes Spalding will retain ownership rights to the photographs, videotapes, digital, and other images. I understand that I will be able to view and/or obtain copies of photographs, videotapes, digital or other images taken for patient care purpose only. Any recordings taken for quality improvement purposes are not available for viewing or copying. I understand that these images will be stored in a secure manner and kept for the time period required by law or outlined in the Hughes Spalding policy. Images that identify the patient will be released and/or used outside the institution for teaching or publication purposes only upon written authorization from me or my legal representative. I further understand that the facility is monitored and recorded by closed circuit television for general and/or clinical purposes.

Children's Healthcare of Atlanta
at Hughes Spalding

RONALD McDONALD CARE MOBILE® CONSENT TO TREAT

The Ronald McDonald Care Mobile's mission is to bring asthma care where kids live, learn, and play.

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

____ By initialing here, I decline to the taking of photographs and/or video recordings for use outside of Hughes Spalding. I understand that this does not pertain to photographs and/or video recordings taken for medical care and treatment purposes.

IX SHADOWING: I understand that from time to time, a non-Hughes Spalding medical staff member and/or other personnel may observe care being rendered by the patient's provider(s).
____ By initialing here, I do not allow anyone to observe the patient's care outside of Hughes Spalding's medical staff and/or other personnel as appropriate and necessary for treatment and care of the patient. I understand that this does not include medical students or other healthcare students placed here through an educational program.

II. OUTPATIENT SERIES: Acting on behalf of the patient, I consent to a continuing course of medical treatment including but not limited to diagnostic tests, physical examinations, and therapeutic services. In addition, with respect to future out-patient services, I consent to treatment by the Ronald McDonald Care Mobile® for the duration of such treatment not to exceed the calendar year in which the original consent was given.
HEALTH INFORMATION EXCHANGES: I understand Hughes Spalding may participate in one or more health information exchange (HIEs) and I consent to Hughes Spalding electronically sharing the patient's health information, including but not limited to, information related to infectious or contagious disease (including HIV and/or AIDS), drug or alcohol abuse or treatment, genetic testing, and/or psychiatric or psychological conditions, for treatment, payment and/or healthcare operations purposes with other participants in the HIEs. I agree that if I do not want the patient's information shared with any HIE in which Hughes Spalding participates, I must opt-out by filling out a form obtained from Children's Privacy Office or found online at http://www.choa.org/hie.

DOWNTIME ROUTINE PROCEDURE

I. I acknowledge and understand that, during the course of my/my child's care and treatment, it is likely that various types of routine diagnostic and treatment procedures ("Procedures") may be utilized, which are considered necessary techniques for the ordinary care and treatment of my/my child's condition(s).

II. While these types of Procedures are routinely performed in hospitals and doctors' offices without incident, there are certain risks associated with each of these Procedures.

III. The provider or his/her associates or assistants are responsible for providing me with information about the Procedures and for answering all of my questions. It is not possible to enumerate each and every risk for every Procedure utilized in modern health care. However, the independent physicians who practice medicine at Hughes Spalding have attempted to identify the most common Procedures, their associated risks and possible alternatives. If I have further questions or concerns regarding these Procedures, I agree to ask my/my child's provider to provide additional information.

IV. The Procedures referenced herein may include, but are not limited to, the following:

a) **Needle Sticks**, such as shots, injections, or intravenous injections (IV's). The risks associated with these types of Procedures include, but are not limited to, nerve damage, causing tingling or burning, infection, swelling, bruising, infiltration (fluid leakage into surrounding tissue), skin sloughing, bleeding, clotting, allergic reactions, or paralysis. Alternatives to Needle Sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.

b) **Physical tests and treatments**, such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, rehabilitation procedures, etc. which may be utilized in conjunction with diagnosis and treatment. The risks associated with these types of Procedures include, but are not limited to, reactions to the material(s) used, infection, bleeding, discomfort, muscular-skeletal or internal injuries, nerve damage, paralysis, bruising, worsening of the condition and/or re-injury. Apart from using modified procedures and/or refusal of treatment, no practical alternatives exist.

c) **Medications/drug therapy** which may be utilized in the care and treatment of patients. The risks associated with these types of Procedures include, but are not limited to, food-drug-herbal interactions; allergic reactions; adverse reactions; and both long-term and short-term side effects which vary from medication to medication. Apart from varying the medication prescribed and/or refusal of treatment, no practical alternatives exist.

(d) **Laboratory testing** which may be utilized when taking samples of blood, bodily fluids and tissue samples for laboratory analysis. The risks associated with these types of Procedures include, but are not limited to, injuries which may occur during the collection of the necessary samples, infection, nerve damage, bleeding, bruising, paralysis, loss of limb, tingling or burning, swelling, and allergic reactions. Apart from refusal of treatment, no practical alternatives exist.

V. I consent to and authorize the persons participating in and responsible for my/my child's care to utilize the Procedures, such as those set forth above, as they may deem reasonably necessary or desirable in the exercise of their professional judgement, including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to the treatment of all conditions which may arise during the course of such Procedures including those conditions which may be unknown or unforeseen at the time this consent is obtained.

VI. I understand that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and/or result of any Procedure.

I understand that the provider, medical personnel, and other assistants participating in the patient's care will rely upon the patient's documented medical history, as well as other information obtained from the patient, the family, or others having knowledge regarding the patient, in determining whether to perform the Procedure(s) or the course of treatment for my/the patient's condition and in recommending the Procedure.

DOWNTIME FINANCIAL CONSENT

I. ASSIGNMENT OF BENEFITS: In consideration of the service provided at Children's Healthcare of Atlanta at Hughes Spalding (Hughes Spalding) to the patient identified above, I hereby assign and transfer to Hughes Spalding and other healthcare providers all hospital and medical provider professional fees payable and related rights, including my rights to appeal any denial of benefits of limitation of coverage existing under the insurance policies or benefit plans that I have identified or will identify in connection with this visit (but not to exceed amount of Hughes Spalding charges for this period of hospitalization or other amounts as may be provided by an agreement between Hughes Spalding and my insurance company). I authorize and direct the insurance company to pay all such benefits to Hughes Spalding and appropriate medical providers, and I appoint Hughes Spalding to act as my authorized representative in requesting an appeal from my insurance company regarding any denial of payment. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurance company and Hughes Spalding.

II. OUT OF STATE MEDICAID: Hughes Spalding does not participate in Out of State Medicaid programs. If I have met the financial criteria to qualify for Medicaid, I may be eligible for Hughes Spalding's charity program. If qualified, a charity adjustment may be applicable for the care delivered. Independent physicians who provide services to me during my treatment at Hughes Spalding will make their own independent decisions whether or not to accept payment from Out of State Medicaid.

III. PRECERTIFICATION: I understand that my insurance policy may require compliance with a utilization review program to make certain that health care benefit funds are expended when justified. I understand that it is the utilization review program's responsibility to review proposed elective admissions and anticipated courses of treatment. I understand that if the utilization review program determines that the admission is necessary and appropriate and issues certification, the benefits of my insurance plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, health care benefits may be withheld. I understand that precertification may be the responsibility of the physician. I understand that my insurance plan's determination that a requested service is medically necessary is not a guarantee of health care benefit coverage. In the event coverage is denied by my insurance plan, I will/shall be financially responsible for all hospital charges incurred as a result of the admission. I understand that to protect myself from unnecessary personal financial losses, I must review my obligations with my insurance company, utilization review program, and personal physician without delay.

IV. GUARANTEE OF PAYMENT: In addition to the bill I receive from Hughes Spalding, I may receive a bill from physicians for professional services rendered, including, but not limited to, "on-call" specialists and sub-specialists. Also, I may receive a separate bill for any services provided by Radiology, Anesthesiology, Pathology or another specialist who provides a service or interprets tests. Although Hughes Spalding may be a provider in my insurance network, the physician may or may not be a participating provider. This may affect my coverage level for professional services. I can contact my Member Services Representative for my plan coverage determination.

Children's Healthcare of Atlanta
at Hughes Spalding

RONALD McDONALD CARE MOBILE® CONSENT TO TREAT

The Ronald McDonald Care Mobile's mission is to bring asthma care where kids live, learn, and play.

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

V. INDIGENT CARE TRUST FUND: Hughes Spalding is a participant in the Georgia Indigent Care Trust Fund. As such, patients and/or responsible parties who meet certain income levels as indicated by the Federal Poverty Guidelines may be eligible for free (or reduced cost for) services offered by Hughes Spalding. Patients and/or responsible parties interested in this program may call the financial counselors for further information.

VI. SELF PAY: I understand that I am financially responsible for charges or any unpaid balances for the patient account listed above. Hughes Spalding has informed me of the availability of financial assistance through Hughes Spalding's financial counseling programs. I acknowledge that I was unable to provide proof of insurance at the time of service, I do not have insurance and/or that services will not be covered by my insurance plan.

VII. COBRA: If you have continuation of insurance from a prior employer, please complete this section.

Previous employer information:

Employer Name _____

Address _____

Phone Number _____

Policy # _____

Insurance Information:

Insurance Name _____

Insurance Phone #_____

Group # _____

*This Ronald McDonald Care Mobile® is made possible by a grant from Ronald McDonald House Charities, Inc., a non-profit, tax-exempt charitable corporation ("RMHC Global"), and by Ronald McDonald House Charities of Atlanta, a non-profit tax-exempt charitable corporation ("RMHC Local"). ***The undersigned acknowledges and agrees that (i) RMHC Global and RMHC Local have no responsibility or liability for the operation of this Ronald McDonald Care Mobile or any of the medical care, dental care and/or health education activities conducted therein and (ii) each of RMHC Global and RMHC Local is fully released from any and all claims arising therefrom.***

DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS

I certify that I have read and understand this consent and have signed below. A copy of Hughes Spalding's Privacy Notice and the Patient Rights and Responsibilities have been made available to me.

_____
Name (please print full name)

_____
Signature

_____
Relationship to Patient

_____
Date/Time

_____
Telephone Witness (if needed)
(please print full name)

_____
Signature

_____
Date/Time

34474-08

Children's Healthcare of Atlanta
at Hughes Spalding

RONALD McDONALD CARE MOBILE® REGISTRATION AND HEALTH HISTORY

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Patient Information: Please complete all of this section

_____ _____

Student's Last Name First Middle

_____ _____

Student's Address City State Zip

_____ Sex: M F

Date of Birth Ethnicity: Hispanic or Latino Non-Hispanic or Latino Other Declined Unknown

Race: American Indian/Alaska Native Asian Black/African American White
Native Hawaiian/other Pacific Islander Other Declined Unknown

School: _____ Grade: _____ Teacher: _____

Primary Care Physician: _____ Date of Last Well-Check: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Parent/Guardian Information:

Parent/Guardian's Name: _____ Parent Date of Birth: _____

Parent Employment status (Please Circle One): Full Time Part Time Self Employed Not Employed Other

Address (if different from student): _____

Preferred Language: _____ Email Address: _____

Home Phone #: _____ Mobile Phone #: _____

May we leave a message? Yes No Preferred form of contact? Call Text Email

Insurance Information: **Please fill in all the information so that we do not need to copy your card.**

My child has: ___ No Insurance ___ Peach State ___ Amerigroup ___ Well Care ___ Medicaid

ID# _____ (ID# required for billing) Effective Date: _____

___Private/Commercial Insurance Provider **(please provide ALL details below)**

Primary Insurance Company: _____ Name of Policy Holder: _____

Policy Holder Date of Birth: _____ Effective Date: _____ Relationship to Student: _____

Member ID or Policy# _____ Group # _____ Group Name: _____

(Please call us if you have any billing questions or concerns throughout the year 404-785-9480)

Screening Checklist for Contraindications to Vaccines for Children and Teens

Patient Name: _____ Date of Birth: _____

1. **Is your child sick today?** **a. If yes, what type of illness does your child have?** _____	○ Yes ○ No
2. **Has your child had a fever in the last 24 hours > 100.5 F?**	○ Yes ○ No
3. **Does your child have any allergies to latex, food, medications or any vaccine?** **a. If yes, what allergies does your child have?** _____ **Vaccines are Contraindicated for the following allergens:** • **Gelatin allergy- Do not administer MMR, MMRV, Varicella** • **Latex allergy- Do not administer Havrix (syringe only), Kinrix (syringe only), Bexsero, Pediarix, Boostrix (Syringe only), Engerix-B (syringe only), Recombivax (Syringe Only)** • **Neomycin or Thimerosol- Kinrix, Pediarix, Pentacel, Havrix, Twinrix, MMR, MMRV, Td, Varicella**	○ Yes ○ No
4. **Has the child had a serious reaction to a vaccine in the past?** **If yes, the following reactions contraindicate future doses:** • **Anaphylaxis** • **Encephalopathy within 7 days of DTP, DTaP** • **Seizure within 3 days of DTaP** • **Pallor or Limp Episode or collapse within 48hrs of DTaP** • **Continuous Crying for >3hours within 48 hrs of DTaP** • **Fever of 105F within 48 hrs of DTaP**	○ Yes ○ No
5. **Has the child received vaccinations in the past 4 weeks?**	○ Yes ○ No
6. **Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?(MMRV, MMR VAR)**	○ Yes ○ No
7. **In the past 3 months, has the child taken medications that affect the immune system such as prednisone other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? (excludes prednisone for asthma)**	○ Yes ○ No
8. **In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? (MMRV, MMR VAR)**	○ Yes ○ No