THE HSC HEALTH CARE SYSTEM

The HSC Outpatient Center

CONSENT FOR TREATMENT

The below agreements are made concerning _____ (patient's name), whose date of birth is ____/____/_____.

Permission for Diagnosis and Treatment - I hereby give consent to the authorities of The HSC Pediatric Center for such diagnostic procedures, treatment and therapeutic activities.

Authorization for Release of Information - I hereby give consent to the authorities of the HSC Pediatric Center to release a patient status report regarding process and condition to referring facilities, physicians, nurses, therapists, and social workers.

Emergency Care of Child - I understand that during the course of treatment at The HSC Pediatric Center, a situation can arise in which the above-named patient would require emergency treatment. I hereby give consent to the HSC Pediatric Center to call 911 to initiate emergency care.

Financial Responsibility and Assignment of Benefits - I understand and agree that I am financially responsible for all charges incurred by the above-named patient. In the case of Medical Assistance coverage, I understand that I am responsible for and will cooperate in the maintenance of eligibility to ensure a continuous payment mechanism for treatment.

_____ **(Initials)** I have given all insurance information to The HSC Pediatric Center as presented and I have no other HMO Coverage.

_____ **(Initials)** I also understand that in the event my assigned insurance benefits do not cover the total liability on the above-named patient, I am responsible for the unpaid portion of the bill.

In the case of insurance coverage, I authorize my insurance company to pay directly to The HSC Pediatric Center and all benefits provided by my policy to the above-named patient.

I authorize The HSC Pediatric Center to release any and all medical record information requested by the carrier in consideration of the claim.

I acknowledge that I have been given the Outpatient Family Handbook containing Patient Rights and Responsibilities, The HSC Pediatric Notice of Privacy Practices, and Advance Directives information. I understand I can ask for clarification from the therapist/manager regarding the handouts/ information.

I am the legal guardian for the patient or 18 years of age and deemed competent for purposes of medical decision making.

	GRANT	DECLINE
Photographic Material-Permission allowing photographs and/or motion pictures to be taken of the above-named patient for use in the patient's medical record, medical education and/or to publicize The HSC Pediatric Center and for demonstrating the purpose and service of the Hospital by publication or use in the appropriate media. No money will be paid for the photographs, and/or motion pictures. The patient's last name will not be used to publicize The HSC Pediatric Center.		

_____ _____ _____ _____

Signature - Responsible Party Date Signature of Witness Date

_____ _____ _____

Printed Name - Responsibility Party Relationship to the Patient Telephone # - Responsible Party

_____

Address - Responsible Party City State Zip Code

Alternate Phone Number _____ Email Address_____

Name/Phone Number of Emergency Contact _____