



Children'sSM
Healthcare of Atlanta
Cardiology

Children's Healthcare of Atlanta Cardiology, Inc.

TREATMENT CONSENT FORM

GENERAL CONSENT TO CARE AND TREATMENT

Name _____

Date of Birth _____

MRN# _____

I. **CONSENT TO TREATMENT:** I hereby authorize and give voluntarily consent to Children's Healthcare of Atlanta Cardiology, Inc. ("Children's Cardiology") and its healthcare professionals to provide the patient with a continuing course of medical treatment. I understand that such treatment may include without limitation routine medical and nursing care; and routine diagnostic testing, including additional laboratory testing at a later date. I further understand that certain treatments and procedures require the execution of a separate Informed Consent Form, and that I will be provided with an Informed Consent Form if any such treatment or procedure is recommended for the patient.

II. **PERSONAL BELONGINGS:** I understand and agree that Children's Cardiology is not responsible or liable for any loss, theft, misplacement or damage of any valuables or personal belongings that I bring with me to the facility, clinic or physician's office.

III. **APPOINTMENT REMINDERS VIA TEXT:** I consent to Children's Cardiology sending text messages to my mobile device for the purpose of reminding me about upcoming appointments at Children's Cardiology, in compliance with applicable privacy policies and requirements that are in effect from time to time. No such contact will be deemed unsolicited. I may be contacted at the cell phone number currently on file with Children's Cardiology. I may opt out of Children's Cardiology text message communications at any time by following the opt-out instructions provided to me via text. I understand that my carrier's message and data rates may apply.

___ By initialing here, I do not give my consent to Children's Cardiology to send text messages to my mobile device for the purpose of reminding me about upcoming appointments.

IV. **SHADOWING:** I understand that from time to time, a non-Children's Cardiology medical staff member and/or other persons may observe care being rendered by the patient's physician(s).

___ By initialing here, I do not allow anyone to observe the patient's care outside of Children's Cardiology's medical staff and/or other persons as appropriate and necessary for treatment and care of the patient. I understand that my refusal does not apply to medical students or other healthcare students placed at the facility through an educational program.

V. **DIGITAL IMAGES:** I understand that digital and other images may be recorded to document the patient's care and I consent to such recordings. I understand that Children's Cardiology will retain the ownership rights to these digital and other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner and kept for the time period required by law or outlined in Children's Cardiology's 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 may be monitored and recorded by closed circuit television for general and/or clinical purposes.

VI. **HEALTH INFORMATION EXCHANGES.** I understand that Children's Cardiology is affiliated with Children's Healthcare of Atlanta (Children's) and Children's may participate in one or more health information exchanges (HIEs). I consent to Children's 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 Children's 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>.



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ROUTINE PROCEDURES

- 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 doctors' offices without incident, there are certain risks associated with each of these Procedures.
- III. The physician 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. If I have further questions or concerns regarding these Procedures, I agree to ask my/my child's physician to provide additional information.
- IV. I consent to and authorize the persons participating in and responsible for my/my child's care to utilize Procedures that they deem reasonably necessary or desirable in the exercise of their professional judgment, 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.
- V. I understand that the practice of medicine is not an exact science and that no guarantees or assurances are made to me concerning the outcome and/or result of any Procedure(s). I understand that the physician, 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 me, the patient, the family or others having knowledge regarding the patient, in determining the course of treatment for my/the patient's condition.

FINANCIAL CONSENT

- I. **PAYMENT RESPONSIBILITY.** I acknowledge that I am responsible for paying for all care that the patient receives at Children's Cardiology, and if my insurance provider or health benefit plan does not cover the full cost of such care, I must pay the remaining balance.
- II. **ASSIGNMENT OF BENEFITS.** In consideration of the services provided to the patient at Children's Cardiology, I hereby assign and transfer to Children's Cardiology and other appropriate health care providers all health care benefits payable and related rights, including my rights to appeal any denial of benefits or limitation of coverage existing under the insurance policies or benefit plans that I have identified or will identify in connection with the patient's medical care. I authorize and direct the insurance company or benefit plan to pay all such benefits to Children's Cardiology, and I appoint Children's Cardiology to act as my authorized representative in requesting an appeal from my insurance company or benefit plan 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 my insurance company or benefit plan, unless otherwise provided in the terms of an agreement between Children's Cardiology and the insurance company or benefit plan.
- III. **COBRA.** If you have continuation of insurance from a prior employer, please provide such information to Children's Cardiology.



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I certify that I have read this Treatment Consent Form, that any questions I had about its contents have been answered, and that I fully understand its contents. This Treatment Consent Form will be valid for all services provided by Children's Cardiology in the calendar year in which it was signed. If I wish to revise my consent, I may do so by completing a new Treatment Consent Form. If I wish to withdraw my consent, I must do so in writing.

A copy of Children's Cardiology's Privacy Notice has been made available to me.

Name (please print full name)

Witness (please print full name)

Signature

Signature

Relationship to Patient: _____

Date/Time: _____

Telephone Witness (please print full name)

Telephone-Witness (please print full name)

Signature

Signature

Date/Time: _____

Date/Time: _____

Signature of Interpreter (or ID# of Phone Interpreter)

Date/Time

ID#

Children's Cardiology complies with applicable Federal Civil rights laws and does not discriminate on the basis of race, color or national origin, age disability, or sex.