**GENERAL CONSENT FOR TREATMENT**

I hereby authorize the physician offices, clinics, and outpatient departments to provide medical care and treatment to me as the physician, resident, intern, physician’s assistant, nurse, dentist, dental assistant, medical assistant, psychologist, nurse practitioner or allied health personnel, or any of their designees (hereinafter “Health Care Providers”) may deem necessary or advisable. This care may include, but is not limited to:

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### THIS AREA MUST BE COMPLETED - PLEASE CHECK APPLICABLE BOX BELOW

- [ ] OUTPATIENT SERVICES (excluding any listed therapies below) *Outpatient services include, but are not limited to: Diagnostic Radiology; Laboratory (including but not limited to: blood, urine, HIV tests); Neurodiagnostic Studies (including but not limited to: ERGs, EEGs and EPs); Administration of drugs, biological and other therapeutics; Routine medical care (including injections).*
- [ ] THERAPIES: Physical Therapy, Occupational Therapy, Speech Therapy/Audiology or superficial wound care

*By signing this agreement, I acknowledge that I have read and understand the information contained herein and that I accept these terms.*

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### ADDRESS TO COMMUNICATE:

I understand that Children's Hospital utilizes various communication methods including voice calls, computerized calls, computerized text messaging, email, fax, auto-dialed calls, and pre-recorded messaging for the purposes of sharing clinical medical results, scheduling appointments, sending appointment reminders, obtaining patient satisfaction information, and communicating/discussing financial responsibilities. By signing this form, I am granting permission to Children's Hospital to utilize all phone numbers that I have supplied to contact me regarding this current visit and any future visits for the above stated purposes. I further understand that I have a right to revoke this authorization at any time by communicating this request to Children's Hospital.

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### RELEASE OF INFORMATION:

I authorize Children's Hospital or any physician treating me at Children's Hospital to release medical or other information to Children's Hospital agents, my primary care or referring physicians, the insurance companies, their agents, transport services, the Social Security Administration (Medicare), the Louisiana Department of Health and Hospitals (Medicaid and SSI), the Children's Special Health Services Program, their intermediaries or carriers, or any third party acting on my behalf or Children's Hospital’s behalf which is needed for benefits to be paid under my insurance or other contracts applicable to claim for treatment. I hereby indemnify and release Children's Hospital from any and all responsibility relative to the release of such information. I understand that Children's Hospital will make any disclosures that are required by law to meet mandatory reporting requirements. I hereby indemnify and release Children's Hospital from any and all responsibility relative to the release of such information.

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### OUTPATIENT SURGICAL PROCEDURES:

This general consent does not extend or apply to any proposed outpatient surgical procedure for which an Informed Consent is required by law or Children's Hospital policy.

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### TEACHING FACILITY:

I have been informed and understand that this facility is a teaching institution and the procedures performed may require observation, cooperation, and services of multiple health care providers. I authorize fellows, residents and/or students to participate in my care.

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### PAYMENT GUARANTEE & INSURANCE AUTHORIZATION/ASSIGNMENT OF INSURANCE BENEFITS:

I agree to pay for all charges for diagnostic procedures and medical treatment that are rendered to me or the named patient. I authorize third parties to pay directly to Children's Hospital any insurance benefits due for services rendered on behalf of me or the named patient. I hereby assign all medical benefits to include major medical benefits for services rendered by Health Care Providers to which I am entitled, including Medicare or Medicaid, private insurance and other health plans to Children's Hospital. I understand, that except as otherwise provided by law or my health insurance issuer’s contract with Health Care Providers, I am responsible for all charges not paid by my insurance company.

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### NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS:

I acknowledge that copies of the Children's Hospital Notice of Privacy Practices and Notice of the Patient’s Rights and Responsibilities have been made available to me.

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### myLCMC HEALTH INFORMATION EXCHANGE (HIE) CONSENT:

I understand that myLCMC Health is a patient portal through which I may access portions of my protected health information. At a future date, all LCMC physicians will become part of LCMC's health information exchange via myLCMC Health and authorized LCMC physicians will also have the ability to access portions of my protected health information. Additionally, at a future date various community physicians and other health information exchanges may become part of LCMC’s health information exchange via myLCMC Health and those who are authorized will also have the ability to access portions of my protected health information. By signing below, I hereby consent to use and opt-in to myLCMC Health.

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### I opt out of having my protected health information put into the myLCMC Health patient portal.

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### CONSENT FOR PHOTOGRAPHY:

I grant permission to Children's Hospital and its Health Care Providers to photograph, videotape, and/or audiotape my child and to use such photographs, videotape and/or audiotape for clinical, educational, and legal purposes.

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### AUTHORIZATION TO LINKS:

LINKS (Louisiana Immunization Network for KIDS Statewide) is a Department of Health and Hospitals’ sponsored confidential computer system that helps you and your doctor keep track of the patient’s immunization history. Children's Hospital is a LINKS participating facility and therefore I am allowing Children's Hospital to share immunization information with LINKS.

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### REVOCATION:

By signing this agreement, I acknowledge that I have read and understand the information contained herein and that I accept these terms.

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### Signature of Responsible Party (Parent/Guardian if patient is under 18 years of age or emancipated)

**X**

**Date**: MM/DD/YY  
**Time**: 00:00 am/pm  
**Relationship to Patient**

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### Signature of Witness (Need only if signature by mark)

**X**

**Date**: MM/DD/YY  
**Time**: 00:00 am/pm  
---
Telehealth involves the use of electronic communication to enable you, the patient, to share and discuss medical information with the provider for the purpose of delivering convenient, efficient, and effective patient care. The laws that protect privacy and confidentiality of medical information also apply to telehealth, so any consultation via telehealth is secure and confidential.

### Potential Risks

I understand the following concerning telehealth consultations:

- Videoconferencing equipment could fail, causing delays in medical evaluation and treatment.
- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the consulting provider.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- I/my child may be required to be seen by or visit the consultant in person if more information is needed to make a diagnosis.

I understand the following concerning telehealth consultations:

- It has been explained to me how videoconferencing technology will be used to facilitate the consultation since the consulting provider and I will not be in the same room.
- Individuals may be present with the consulting provider to operate equipment or to assist with evaluation, examination and/or treatment. I will be told if there are other people present.
- I have the right to: (1) ask non-medical personnel to leave the room; and/or (2) stop the consultation at any time.
- If my telehealth consultation is not able to be completed for any reason (such as equipment failure), I may work with Children’s Hospital personnel to reschedule. If I/my child need care emergently, I will either call 911 or go to the nearest emergency room without delay.
- The alternatives to a telehealth consultation have been explained to me, and I have chosen for me/my child to participate in a telehealth consultation.
- I understand the role of the physician and the patient and the role of any other healthcare providers with respect to management of the patient.
- I understand that Children’s Hospital’s telehealth consultation services should never be used for urgent matters. Therefore, for all urgent health care matters, I will go to or I will bring my child, without delay, to the emergency department of a local hospital, and/or dial 911.
- I have the right to withhold or withdraw my consent to the telehealth consultation at any time without affecting my/my child’s right to future care, treatment, benefits, or programs for which I/my child may be eligible.
- I understand that these video conferences are not routinely recorded. However, there may be instances in which the health care provider may need to obtain a photograph or video or audio recording. By signing below, I grant permission to Children’s Hospital and its health care providers to photograph, videotape, and/or audiotape my child and to use such photographs, videotape and/or audiotape for clinical, educational, and legal purposes.
- I have the right to access a copy of my/my child’s medical records. I have been provided with a copy of Children’s Hospital’s Notice of Privacy Practices, which includes instructions for how to do so.
- I understand my/my child’s healthcare information may be shared with other individuals for scheduling and billing and insurance purposes as well as the payer’s (insurance company) case management staff.
- I understand that the provider will bill my insurance or Medicaid for these services. I understand that I may be responsible for payment of services, copayment or coinsurance if required by my insurance company.
- I understand that telehealth video visits are a service of Children’s Hospital, not the school. The school, district, charter, or parish school system will not be held liable for unpaid bills.
- I understand that if I/my child need to or would like to receive follow-up care from this health care provider, I can contact Children’s Hospital at (504)-899-9511.
- I understand that if my/my child’s account may not be available to me at all times due to unanticipated technology or system failures, back-up procedures, maintenance, or other causes beyond the control of the Children’s Hospital or its authorized vendors and agents. Access is provided on an "as-is as-available" basis and Children’s Hospital or its authorized vendors and agents do not guarantee that I will be able to access my account at all times. In the event of such a technology or system failure, I can call (888)-666-2352 or go to [https://www.chnola.org/our-services/telehealth/contact-us/] for assistance or to pursue further care.
- I understand that I may decline to receive medical services by telemedicine and may withhold or withdraw my consent from such care at any time without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting my Healthcare Provider. As long as this consent is in force (has not been revoked) my healthcare team may provide healthcare services to me via telehealth without the need for me to sign another consent form.

<table>
<thead>
<tr>
<th>Parent/ Guardian’s Signature:</th>
<th>Date MM/DD/YY</th>
<th>Time 00:00 AM/PM</th>
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<tbody>
<tr>
<td>X</td>
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<th>Student’s Printed Name:</th>
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I have read and understand the information provided above regarding telehealth. I consent (agree) to participate in the School Based Telehealth Program under the terms stated above.

*FOR OFFICE USE ONLY* By signing below, I confirm that verbal consent to treat was obtained from the legal guardian of the student prior to initiating a video visit. Guardian’s signature above acknowledges that verbal consent was given before written consent.

<table>
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<tr>
<th>Telehealth Presenter’s Signature:</th>
<th>Date MM/DD/YY</th>
<th>Time 00:00 AM/PM</th>
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This enrollment form will be used for reference at the time of your child’s video visit.

General Information

Student Name: ___________________________________________  
Last     First     M  
Student Date of Birth: _____________________ Sex: □ Male  □ Female  
Primary Care Provider: _______________________________  
Primary Care Provider's Phone Number: _______________________  
Parent / Guardian Name: __________________________________  
Parent / Guardian DOB: ___________________________ Relationship to Student: ___________________  
Parent / Guardian Email: __________________________________  

Student’s Primary Information:

Address: ___________________________________________  
City: ___________________________ State: _______ Zip:______________________  

Primary Phone*: _______________________  □ Home  □ Cell  □ Work  
*We will call this number if a video visit is needed  
Secondary Phone: ___________________________  □ Home  □ Cell  □ Work  

Payment / Insurance Information:

Note that the visit is only billed upon successful completion of the video visit. If this information changes without notification or is incorrect, a bill may be sent to the address above.

□ Medicaid Number: _______________________  
Medicaid Plan: _______________________  
□ Private Insurance Plan: _______________________  
Policy Number: _______________________  

Name of person under whom student is insured: ___________________________________________  
Relationship: _______________________  DOB: _______________________  

□ No Insurance  

Note that the video visit will be billed to the parent / guardian listed above  

Please list any:  

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<th>Known allergies</th>
<th>Current medications</th>
<th>Major medical procedures or events</th>
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</table>

By submitting this form, I acknowledge that my child’s information may be entered into the Children’s Hospital Electronic Health Record.

Patient/ Guardian’s Signature:  

X

Date MM/DD/YY  
/  
Time 00:00 AM/PM  
:

QUESTIONNAIRE  
CH2053  | (08/19) New  
*EL245*
Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

This Notice of Privacy Practices (“Notice”) is provided to you as a requirement of the Health Insurance Portability and Accountability Act (“HIPAA”). We are required by law to post the terms of this Notice and to maintain the privacy and secu- rity of your protected health information. To this end, we have prepared this Notice so that you understand the uses and disclosures of your protected health information that may occur when you receive health services from us. If you have any questions about this Notice, please ask us.

We may use or disclose your information to contact you for fundraising activities. If you do not want to be contacted for fundraising activities, you may let us know this by sending your request to the Business Activities office. We may use or disclose your information to create “de-identified” information in ac- cordance with applicable law.

“Business Associates.” Business associates are companies or people we contract with to do certain work for us. Examples include providing information to a copying service we use when making copies of your health information, or providing medical equipment that we may have contracted with for the purpose of providing health services. We require the business associate to agree to take reasonable steps to protect the privacy of your medical information.

Limited Data Set. If we use your information to make a “limited data set,” we may give the “limited data set” that includes your information to others for the purpose of research, public health action on the behalf of the Centers for Medicare & Medicaid Services, or to health care operations personnel who receive the “limited data set” are required to agree to take reasonable steps to protect the privacy of your medical information.

The Secretary of the United States Department of Health & Human Services. The Secretary, or designee, has the right to see and act on your information in order to ensure compliance with applicable law.

Public Health Authorities. We may disclose your medical information to public health authorities authorized to receive your information for the purpose of promoting public health, investigating, or preventing disease, injury, or ill health; or to prevent or control disease, injury, or ill health and to maintain health information that we maintain. The new Notice will be available, upon request in our Facilities and on our website.

Who will follow this notice

LCMC Health is a health system operating as an Organized Health Care Arrangement (“OHCA”). This Notice describes the privacy practices of LCMC Health and its affiliated en- ties and facilities. LCMC Health entities (each, a “Facility”) include, but are not limited to: Children’s Hospital, Touro In- firmary, University Medical Center New Orleans, New Orleans Women’s Medical Center and LCMC Health Anesthesia Corp., and each Facility’s subsidiaries and affiliates and all associated clinics, facilities, and other ser- vice-vi
dic
ties.

All LCMC Health entities and Facilities participate in the OHCA and follow these same Notice provisions for all their entities and Facilities. An entity or Facility in the OHCA may share your medical infor-
mation with each other for treatment, payment, or healthcare operation relating to the OHCA, and may share this information with entities or Facilities if a breach occurs that involves recent acquisitions or sales of entities, sites, or locations. This Notice additionally applies to all employees, volunteers, students, and health-care providers of any LCMC Health affiliated Facility or entity.

Our uses and disclosures

We typically use or disclose your medical information in the following ways:

To Provide Patient Care To You. Your medical information may be used or shared by the doctors, nurses, technicians, residents, medical students, or other personnel who are involved in taking care of you. Different departments of the hos- pital, as well as the different entities, may also share med- ical information about you in order to coordinate the different things you may need, such as prescriptions, lab work, X-rays, and follow-up care. We may disclose medical information about you to people and entities outside the hospital who may be involved in your ongoing medical care. For example, a doctor treating you for an injury may ask another doctor about your overall health condition.

To Obtain Payment. Your medical information may be used or shared to prepare your bill, collect, and process payments from you, or your insurance company, employer, or government program (Medicare, Medicaid, Veteran’s Comp., etc.), or other person who is responsible for payment. For example, we give information about you to our insurers for payment or our operations with your health insurer. We will say “yes” if it would affect your care. If you pay for a service or healthcare item out-of-pocket in full, we can not ask you to sign such a release or consent, and we may not bill you for your healthcare service. We can use medical information that you provide (either oral or written) about you to contact you for your care and to notify them where you are, about your condition, or of your death. If it is an emergency, or you are not able to communicate, we may still give certain information to a person who can help with your care.

Disaster Relief. We may share your medical information with a public or private disaster relief organization assisting with a disaster or emergency.

Other uses of your medical information

Other uses and disclosures of your medical information not covered by this Notice, or required by law, will be made only with your written consent or as otherwise allowed by law.

Right to Obtain an Electronic or Paper Copy of Your Medical Record.

You also have the following rights regarding your medical in-

Right to Obtain a Copy of Your Medical Record. You have the right to see or get an electronic or paper copy of your medical record. To request copies of your medical record, please ask us to give you this Notice. The Secretary of the United States Department of Health & Human Services may want to read it. It is in 45 CFR part 164.

For our Healthcare Operations. Your medical information may be used or shared to run our organization, review the quality and appropriateness of the care you receive, and con-tact you when necessary. For example, we use health infor-
mation about you to manage your treatment and services. We may also use or share your healthcare information to perform healthcare operations on behalf of the organized healthcare arrangement described above.

To Create De-Identified Data Sets. We may use your health infor-
mation to create “de-identified” information in ac-

Other ways we may use or disclose your information

In addition to using or sharing your medical information for our own treatment, payment, and healthcare operations as described above, we may use or share your information as follows:

As Required by Law. We will disclose health information about you if we are required to do so by federal or state law.

People to Whom You Ask Us to Give It. If you tell us that you want us to share your medical information, we will do so.

We will need to fill out an authorization form which gives us permission to release your medical information. You may stop this authorization at any time by writing to us at the address listed above. We are required to give you permission to give your medical information to anyone. We cannot refuse to treat you because you stop this authorization.