CHILDREN'S HOSPITAL

GENERAL CONSENT FOR TREATMENT

PLACE PATIENT'S LABEL HERE

AUTHORIZATION 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:

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***

I authorize the Health Care Providers to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to the results of such diagnostic procedure or treatment.

AUTHORIZATION 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.

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 idemnify and release Children's Hospital from any and all responsibility relative to the release of such information.

DO NOT WRITE OUTSIDE BOX

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.

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.

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.

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.

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.

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

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.

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.

REVOCATION: I understand that this consent may be revoked by me in writing at any time by conveying my desire to revoke my consent to a registration desk at Children's Hospital.

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

Signature of Responsible Party (Parent/Guardian if patient is under 18 years of age or unemancipated)	**Date** MM/DD/YY	**Time** 00:00 am/pm
X	/ /	AM PM
Relationship to Patient		
Signature of Witness (Need only if signature by mark)	**Date** MM/DD/YY	**Time** 00:00 am/pm
X	/ /	AM PM

Children's Hospital
New Orleans
LCMC Health

CONSENT FOR TELEHEALTH SERVICES

PATIENT INFORMATION

PLACE PATIENT'S LABEL HERE

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 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.

Parent/ Guardian's Signature: X	**Date** MM/DD/YY / /	**Time** 00:00 AM/PM :

Student's Printed Name: _____

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.

Telehealth Presenter's Signature: X	**Date** MM/DD/YY / /	**Time** 00:00 AM/PM :

Children's Hospital
New Orleans
LCMC Health

SCHOOL BASED TELEHEALTH PROGRAM ENROLLMENT FORM

PATIENT INFORMATION

PLACE PATIENT'S LABEL HERE

*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:

Known allergies	Current medications	Major medical procedures or events
1.	1.	1.
2.	2.	2.
3.	3.	3.

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

QUESTIONNAIRE

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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 review it carefully.

This Notice of Privacy Practices ("Notice") is provided to you as a requirement of the Health Insurance Portability and Ac- countability Act ("HIPAA"). We are required by law to follow the terms of this Notice and to maintain the privacy and secu- rity of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

The law requires us to make sure that medical information that tells who you are is kept private. It also requires us to give you this Notice of our legal duties and privacy practices to tell you what we do with the medical information about you. To better understand this law, you may want to read it. It is in 45 CFR part 164.

We reserve the right to change the terms of this Notice at any time and to make the new Notice provisions effective for all protected 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 enti- 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 Orle- ans East Hospital, West Jefferson Medical Center and LCMC Health Anesthesia Corp., and each Facility's subsidiaries and affiliates and all associated clinics, facilities, and other ser- vice delivery sites.

All LCMC Health entities and Facilities participate in the OHCA and follow this same Notice. All of the entities and Facilities participating in the OHCA may share your medical informa- tion with each other for treatment, payment, or healthcare operation relating to the OHCA, and as otherwise permitted by applicable law. This list may not reflect 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. These descriptions do not list every permitted use or disclosure in each category.

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 in- volved in taking care of you. Different departments of the hos- pital, as well as the different entities, may also share medi- cal 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 as well as from any insurance company, govern- ment program (Medicare, Medicaid, Worker's Comp., etc.), or other person who is responsible for payment. For example, we give information about you to your health insurance plan so it will pay for services.

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 Databases. We may use your health information to create "de-identified" information in ac- cordance with applicable law. After removing information that tells anyone who you are, your de-identified limited medical information may be put into a computer program which may be used for research purposes. If your information is partially de-identified, it is called a "limited data set," and may be used for similar research purposes in accordance with applicable law and regulations.

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 give your medical information to someone, we will do so. You 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. We are not allowed to force you to give us permission to give your medical information to anyone. We cannot refuse to treat you because you stop this authorization

Activities. We may use or disclose your information to contact you for fundraising activities. If you do not want to be contacted for fundraising efforts, you have the right to opt-out of such communications.

"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 record, or an auditor who may re- view hospital bills for appropriate charging processes. To protect your health information, we require the business associate to appropriately safeguard your information.

Limited Data Set Recipients. 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 or health care operations. The persons 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 your information in order to make sure we follow the law.

Public Health Authorities. We may disclose your medical information to a public health authority responsible for preventing or controlling disease, maintaining vital statistics or other public health functions. We may also give your medical information to the Food and Drug Administration in connection with FDA-regulated products.

Health Oversight Activities. We may give your medical information to agencies responsible for health oversight activities, such as investigations and audits of the health care system or benefits programs, as allowed by law.

Public Health and Safety. We can share information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect or domestic violence, or preventing or reducing a serious threat to anyone's health or safety.

Workers' Compensation. We can use or share health information about you for workers' compensation claims.
Law enforcement officers. We may share your medical in- formation in response to certain law enforcement requests, including:
in response to a court order, subpoena, warrant, summons, or similar process;
to help identify or locate a suspect, fugitive, material witness or missing person;
in response to inquiries as to the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement;
in response to inquiries regarding a death we believe may be the result of criminal conduct;
in response to inquiries regarding criminal conduct at a Facility; and
in emergency situations to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Courts and Administrative Agencies. We may share health information about you in response to a court or administrative order, or in response to a subpoena.

Coroners. We may share medical information about persons who have died to coroners, medical examiners, or funeral directors, as allowed by law.

Organ Transplant Services. We may share your medical in- formation with organ procurement organizations.

Research. We may use or share your medical information in connection with certain research activities after going through a special approval process for that research.

Correctional Institutions. We may share medical information about you with a correctional institution or law enforcement official if you are an inmate of a correctional institution or in the custody of a law enforcement official. This release would be necessary for: (1) the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Specialized Governmental Functions. We may share your medical information for certain specialized governmental functions, as allowed by law. Such functions include:
Military and veteran activities;
National security and intelligence activities;
Protective service to the President and others;
Medical suitability determinations;
Correctional institutions; and
Other law enforcement custodial situations.

Special Categories of Information. In some circumstances, your medical information may be restricted in a way that limits some of the uses and disclosures described in this Notice. For example, there are special restrictions on the use or disclosure of certain categories of information, e.g. tests for HIV, treatment for mental health conditions, or alcohol or drug abuse related treatment information.

Objections to uses and releases/disclosures

In certain situations, you have the right to object before your medical information can be used or released. This may not apply if you are being treated for certain mental or behavioral problems. If you do not object after you are given the chance to do so, your medical information may be used in the following ways:

Patient Directory. In most cases, this means your name, room number and general information about your condition may be given to people who ask for you by name. Also, information about your religion may be given to members of the clergy, even if they do not ask for you by name.

Family and Friends. We may release to your family members, other relatives, and close personal friends, any medical information that they need to know if they are involved in caring for you. For example, we can tell someone who is assisting with your care that you need to take your medication or get a prescription refilled, or give them information on how to care for you. We can also use your medical information to find a family member, a personal representative, or another person responsible 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 permission. In the following cases we will never share your information unless you give us written per- mission: (1) marketing purposes, (2) sale of your information, and (3) most sharing of psychotherapy notes. If you provide us permission to use or disclose such medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, this will stop any further use or release of such medical information for the purposes covered by your written authorization, except if we have already acted in reliance on your permission.

Your rights regarding your medical information

You also have the following rights regarding your medical in- formation:

Right to Obtain an Electronic or Paper Copy of Your Medical Record. You can ask to see or get an electronic or paper copy of your medical record we have about you. All requests must be in writing. Ask us how to do this. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost- based fee.

Right to Request Restrictions. You can ask us not to share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and may say "no" if it would affect your care. If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share information for purpose of payment or our operations with your health insurer. We will say "yes" to such a request unless a law requires us to share that information.

Right to Request Confidential Communications. You have the right to ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. Ask us how to do this.

Right to Amend. If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. Ask us how to do this. We may say "no" to your request, but we will tell you why in writing within 60 days.

Right to an Accounting of Releases/ Disclosures. You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, with whom we shared it, and why.

We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Right to Receive a Paper Copy of this Notice. You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly. To obtain a paper copy of this Notice, contact the Facility's Privacy Officer or pick one up from the Patient Access Registration Area of one of our Facilities.

Right to File a Complaint. You have the right to file a complaint with us or to the United States Department of Health & Human Services Office of Civil Rights if you believe that we have violated your privacy rights. To complain to us, please contact the Facility's privacy officer at the phone number listed below, or in writing to the following address:

Privacy Officer
Children's Hospital
200 Henry Clay Avenue
New Orleans LA 70118
504.894.5395

You will not be penalized or otherwise retaliated against for filing a complaint.

Right to Choose Someone to Act for You. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choic- es about your health information. We will make sure this person has this authority and can act for you before we take action.

This notice is effective April 6, 2018