The Children's Heart Clinic

NAME:

PATIENT CONSENT

DOB:

TO OUR PATIENTS: Before you begin treatment at The Children's Heart clinic (CHC), the law requires that we explain your rights and responsibilities while a patient at CHC. If you have a complaint or concern about your care, please discuss it first with your care provider. If your concern remains unresolved, you may call the Patient Representative office (612-813-8800). Please read and sign this form below. Ask questions if you do not understand it. If you need a language interpreter, we can provide one for you.

Initial Box to indicate approval

Initial	
☐	**CONSENT FOR TREATMENT:** By signing this form, I consent to and authorize my health care provider to examine and treat me today. I understand that this could include lab tests, x-rays, education or other diagnostic procedures. I understand that my provider is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment.
☐	**RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW:** I understand that it is important that medical providers have access to any of my medical records which will help them to safely treat me and manage my medical care. I agree that a copy of medical records, with the exception of psychotherapy notes, may be sent to any of my physicians health providers, for purposes of my medical care and for business operations. I also agree that CHC can release my medical records to accrediting or regulatory agencies if those agencies request my records and if the law allows those agencies access to my records. **(Records are not automatically sent to your referring physician. They must be requested.)**
☐	**INSURANCE / MEDICARE / MEDICAID ASSIGNMENT OF BENEFITS-PAYMENT OF CHC MEDICAL BILLS:** I would like a "third party payor" (for example, my insurance company/Medicaid/Medicare or its related organizations) to pay the bills for my services at CHC, to the extent the Payor is required to do so under my policy of insurance or the law. Therefore, I request that payment of my bills by the "third party payor" be made to CHC on my behalf for any services furnished to me by or in CHC. I assign the benefits payable for physician services to the physician or organization furnishing the services. In consideration of clinic visits, I agree to pay CHC for all charges not covered by any third party payor.
☐	**RELEASE OF MEDICAL RECORDS FOR BILLING PURPOSES:** In many instances, a "third party payor" will pay a portion or all of my my medical bills related to today's visit. Examples of "third party payors" are medical and auto insurance companies, worker's compensation insurance carriers, Medicaid, Medicare or its related organizations. In order for a "third party payor" to pay any or all of my bills related to today's visit at CHC I understand the "third party payor" may require information about the medical care and treatment I received. I authorize CHC or its related entities to release to the "third party payor" any information needed to determine the payments related to the medical treatment I receive.
☐	**RELEASE OF MEDICAL RECORDS FOR RESEARCH REVIEW:** Sometimes medical records are reviewed to answer research questions about how care is delivered and the quality of that care. For example, information about Cardio myopathy is studied in the hope of finding even more effective treatment. These are important questions for the health of the community. For these studies, data about people are combined. You would not be personally identified. In other words, your identity and medical conditions are kept private and confidential. No personally identifiable information would go outside CHC. Checking this box means that your records can be reviewed by select individuals at CHC for help in these kinds of studies. It also means that you may be contacted by your provider about your interest in a study. Checking this box means that your records can be reviewed for these kinds of studies. Checking this box does not affect your treatment in any way.
☐	**PATIENTS RIGHT TO PRIVACY:** I acknowledge that I have been made aware of CHC's privacy practices, which are posted in the reception area. I have been given a copy of CHC's notice of Privacy Practices.
☐	**AUTHORIZATION TO COMMUNICATE VIA E-MAIL, ANSWERING MACHINE, ETC:** I authorize CHC to leave messages for me on my home answering service or e-mail if I have provided that information.

I understand I have the right to revoke this consent, in writing, at any time except where The Children's Heart Clinic has already made a disclosure in reliance on this consent.

DATE_____________________________________ PATIENT DATE OF BIRTH ____

SIGNATURE OF
PATIENT / OTHER X _______________________ PRINT NAME ____

IF OTHER, REASON PATIENT
RELATIONSHIP TO PATIENT ________________ UNABLE TO SIGN ____

Authorization will expire 5 years from date noted unless revoked in writing