



NATIONWIDE CHILDREN'S

When your child needs a hospital, everything matters.™

PATIENT IDENTIFICATION

MOBILE CARE CENTER/SCHOOL-BASED SERVICES CONSENT FOR SERVICE

My Child _____
has my permission to be seen and treated by the health care provider(s) from Nationwide Children's Hospital at the Mobile Care Center and/or School-Based Services. This permission remains valid for the entire school year.

I understand I will receive either a written or phone follow-up report when my child is seen. I also give permission for the health care provider to review the School Health Records for any information related to my child's health.

I understand that a written report will be sent to my child's doctor when necessary.

Name, phone/address of child's doctor or clinic (if they have one):

I understand that I have the right to take part in decisions about my child's healthcare and plan for treatment. I have received a copy of the Patient Rights and Responsibilities, and my questions have been answered.

I understand that Nationwide Children's Hospital is a teaching hospital and that my child may be included in its teaching, research, and training programs. I also understand that I may be contacted for participation and/or follow-up regarding such programs.

I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me about the result of my child's examination.

I consent to let Nationwide Children's Hospital share/exchange medical information and other records concerning my child/ward including clinical research, physical, mental, drug alcohol, HIV or AIDS (including information that state and federal law and accreditation agencies require) to/with the school nurse and my doctors, and/or to any insurance company or organization that helps pay my bill. The Hospital may also give information to any welfare organization to which I have applied or may apply for aid.

I assign to Hospital, my physician and other healthcare professionals involved in my care, all my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available to pay the Hospital for medical services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

I have a right to see a list of prices for common medical and surgical procedures. I can ask the Patient Accounts department about this price list or about my bill.

I hereby acknowledge that I was offered a copy of the Notice of Privacy Practices of Integrated Child Healthcare Arrangement (ICHA) which sets forth the ways in which my child's protected health information may be used or disclosed by the Hospital and outlines my rights with respect to such information.

Medical services provided on the Mobile or at the school are billable services and may be billed directly to your insurance company. If you do not have insurance for your child please contact Patient Accounts at 722-2055 for assistance.

BY SIGNING, I CONFIRM THAT I HAVE LEGAL ABILITY TO CONSENT FOR THE TREATMENT.

Printed name: _____ Relationship: _____
Parent/guardian

Signature: _____ Date: _____ Time _____
Parent/guardian

Witness: _____ Date: _____ Time _____
(example: neighbor, adult relative)

PATIENT'S BILL OF RIGHTS:

As a patient, parent or guardian at Nationwide Children's Hospital, you can expect to:

1. Be partners with the hospital staff in your care or the care of your child.
2. Be called by your name and be given the names of the doctors, nurses, and others who provide care.
3. Receive care from hospital staff who respect your personal values, beliefs and customs regardless of your race, ethnicity, gender, religion, sexual orientation, gender identity or expression, cultural background, income level (socioeconomic status), physical or mental disability, education or illness.
4. Have hospital staff listen to what you say, value your opinions and choices, and answer your questions. Know that you can take part in developing your plan of care and that you can express your feelings and receive caring responses.
5. Receive prompt, thoughtful care that keeps your daily routine as normal as possible and respects your need to rest and to learn.
6. Have a family member of your choosing and physician notified of your admission to the hospital.
7. Have family and friends around to comfort and help take care of you when they are able, and have another person who can make decisions about care and treatment when you are not able to.
8. Be given pain relief and other forms of comfort care when needed, and not be restrained unless it must be done for your safety or the safety of others.
9. Receive care and treatment in a safe and clean setting, and be protected from harassment and abuse of any kind.
10. Be given as much information as you need to help you decide whether to consent to treatment or refuse it.
11. Have access to an interpreter if needed.
12. Have privacy during exams and treatment and have the information about your illness kept private.

13. Have access to your medical record unless restricted by law. No one else will be given your medical information without your permission unless allowed by law.

14. Be taught what you need to know and do when you go home. Have assistance in securing home care services for your post hospital care when they are needed.

15. Make a suggestion or complaint to the unit or clinic manager or the Family Relations office you can reach the Patient & Family Relations Office in person or by phone at 614-722-6594 and have your complaints heard and/or resolved. You may also make a report to the Ohio Department of Health at 1-800-342-0553 or you may contact The Joint Commission at 1-800-994-6610.

16. Have the right to decide on and to document an advance directive as allowed by law and have hospital staff and doctors comply with your wishes.

17. Examine your medical bills and have the charges explained to you.

18. Have the right to consent to or refuse to take part in any research program.

As a patient, parent or guardian at Nationwide Children's Hospital, it is your responsibility to:

1. Wear Nationwide Children's Hospital ID badge at all times.

2. Give complete information about your health.

3. Follow your treatment plan and tell your health care team if you have pain or changes in condition.

4. Tell those who care for you when you do not understand your care or what is expected of you.

5. Know that if you refuse treatment, you are responsible for the outcome.

6. Follow the hospital's rules out of respect for other families and hospital staff. This includes respect for the property of others, controlling noise, and following the no-smoking policy.



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Mobile to Mobile Close to Home Centers PATIENT INFORMATION FORM

PATIENT IDENTIFICATION

Date: _____

Child's Name: _____ DOB: _____ Sex: _____ Child's Social Security #: ____-____-____

Race: _____ Ethnicity: _____ (see back of form for Race & Ethnicity categories)

Child's School / Grade: _____ Home Phone: _____

Address _____ Apt # _____ City _____ Zip _____

Emergency Contact Name / Number: _____

FAMILY INFORMATION

Are your children eligible for the Free Lunch Program in the School? Yes No

Mother's Name: _____ DOB: _____ Social Security #: ____-____-____

Home Phone: _____ Daytime/Work Phone: _____ Cell Phone: _____

Address _____ Apt # _____ City _____ Zip _____

Employer: _____ Legal Guardian: Yes No

Father's Name: _____ DOB: _____ Social Security #: ____-____-____

Home Phone: _____ Daytime Phone: _____ Cell Phone: _____

Address _____ Apt # _____ City _____ Zip _____

Employer: _____ Legal Guardian: Yes No

HEALTH INFORMATION

Doctor's Name/Address/Phone #: _____

Pharmacy Name/Location/Phone #: _____

Does your child have any allergies to any medicine?

Yes No Name of Medicine (s): _____

Is your child taking any medications now?

Yes No Name of Medicine (s): _____

Does your child have any Health problems?

Yes No If yes, please describe: _____

INSURANCE INFORMATION

Medicaid Medicare Molina Caresource Other

Private Insurance Plan Aetna UHC Anthem Medical Mutual Group & ID #: _____

Insurance Address _____

None **—————> Do you need insurance? Got you covered-**

Sign up for **free health insurance!** Caresource and Molina are companies that provide managed care Medicaid insurance for qualified children. Call 221-2255 to make an appointment. You'll meet with a counselor from Nationwide Children's Hospital to determine your child's eligibility and to gather information to enroll or recertify your child for Medicaid.

FOR QUESTIONS REGARDING YOUR CHILDS CARE OR ACCOUNT CONTACT:

NATIONWIDE CHILDREN'S YELLOW MOBILE: 614-306-1005 PATIENT ACCTS: 614-722-2055

RONALD MCDONALD CARE MOBILE: 614-795-8752

Race: Biological and inherited physical appearance of a person, color of skin, hair and eyes, bone and jaw structure, etc. A patient's race does not change.

Ethnicity: Groups with similar traits such as a common language, common heritage, and cultural similarities. It is often the same geographical locations, ancestry, foods, and beliefs. It may be often stereotyped by dominant groups.

Race

African	Latino/Hispanic/Black	White
American Indian/Alaska Native	Latino/Hispanic/Unspecified	
Asian	Latino/Hispanic/White	
Bi-racial/Multi-racial	Native Hawaiian & Other Pacific	<i>Patient/Family Declined</i>
Black/African American	Islander	<i>Guardian Unavailable to Ask</i>

Ethnicity

Afghanistani/Afghan/Afghani	Egyptian	Moroccan
African	Eritrean	Nepalese/Nepali
Alaskan	Ethiopian	Nicaraguan
Albanian	European	Nigerian
American	Filipino	Pakistani
American Indian	French	Palestinian
Appalachian	Gambian	Polish/Pole
Arab/Arabic	German	Portuguese
Asian Indian	Ghanaian/Ghanian	Puerto Rican
Assyrian	Greek	Russian
Bahamian	Guatemalan	Salvadoran
Bangladeshi	Guinea	Scottish
Bantu	Haitian	Senegalese/Senegal
Bolivian	Honduran	Sierra Leonean
Brazilian	Hong Kong	Singaporean
Bulgarian	Indonesian	Somali
British/English	Iranian	South American
Burmese	Iraqi	South American Indian
Cambodian	Irish	Spanish
Cameroonian	Israeli	Sri Lankan
Canadian	Italian	Syrian
Cape Verdean	Jamaican	Taiwanese
Caribbean Islander	Japanese	Thai
Central African	Kenyan	Trinidadian
Central African Republic	Korean	Turkish/Turk
Central American	Kurdish/Kurd	Ugandan
Chinese	Laotian/Lao	Ukrainian
Colombian	Lebanese	Uzbek/Uzbek
Costa Rican	Liberian	Vietnamese
Cuban	Malaysian	West Indian
Dominica Islander	Mexican	Western African
Dominican	Mexican American	Zairean
Eastern African	Mexican American Indian	<i>Other Ethnicity</i>
Eastern European	Middle Eastern/North African	<i>Multi Ethnicity</i>
Ecuadorian	Mnong	<i>Patient/Family Declined</i>
		<i>Guardian Unavailable to Ask</i>