NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

ONE YEAR AMBULATORY GENERAL CONSENT

PATIENT IDENTIFICATION

Consent for Medical Treatment:

I and/or my parent(s) or guardian(s)* consent to let the doctors, nurses, and employees of Nationwide Children's Hospital, attending doctors and other doctors,** (or assistants/designees) or persons, do all things that may be needed to diagnose, treat and care for the needs of above-referenced patient.

(* Throughout this document the use of the term "I" will refer to "I and/or my parents or guardians." The use of the term "me" "myself" or "my" shall refer to the patient. The use of "the Hospital" will refer to Nationwide Children's Hospital, its attending doctors, other doctors, or agents of the hospital.)

The Hospital may keep, preserve and use, or properly dispose of any tissue, samples, parts or organs that are taken during operation(s) or procedures(s). These specimens may be used for diagnostic, teaching or research programs.

I understand this is a teaching hospital and that I am 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 as applicable.

I authorize Hospital to take photos, video, or audio recording of me for diagnostic, teaching, identification, care conferencing, research, research publication, academic publication, and quality improvement purposes.

I understand that the Hospital is not responsible if any of my clothes or belongings are lost. I am aware 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 examination or treatment at the Hospital.

Patient Rights and Responsibilities (see the other side of page):

I understand I have the right to take part in decisions about my health care and plan for treatment. I have the responsibility to wear my patient identification at all times while at the Hospital. In addition, my parents/family/guardian/visitors have the responsibility to wear their Hospital identification at all times. I have received a copy of the Patient Rights and Responsibilities, and my questions have been answered.

Consent to Release Medical Information:

I consent to let the Hospital share/release/exchange information such as clinical research, physical, mental, drug alcohol, HIV or AIDS (including information that state and federal law and accreditation agencies require) to/with my doctors, my referring doctors, or referring/referral health care provider; 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.

Assignment of Insurance Benefits:

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.

Financial Responsibility:

I (or my guarantor, if appropriate) will pay all bills for my care including bills that insurance benefits do not pay. This includes bills from the hospital, physicians or any other entities that provided services during my care. I certify that the information I have given the Hospital regarding my family size and income is accurate to the best of my knowledge.

Nationwide Children's Price Disclosure:

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.

Removal from Nationwide Children's Hospital:

If I decide to stop my medical care against the advice of doctors, I understand that the Hospital and doctor(s) are not responsible for any bad result after I leave.

Acknowledgment of Receipt of Notice of Privacy Practices:

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 protected health information may be used or disclosed by the Hospital and outlines my rights with respect to such information.

Consent for Automated Calls and Texts:

I expressly authorize Nationwide Children's Hospital, its affiliated entities, and third party service providers to call or text me at any wireless phone number associated with my account(s), including any phone number that may result in charges to me, whether provided in the past, present, or future. I agree that methods of contact may include use of pre-recorded or artificial voices or an automatic dialing system. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services from Nationwide Children's.

One Year Ambulatory General Consent

I agree that this Consent will be effective for one year from the date of signature when the patient arrives in an ambulatory setting, such as Outpatient Lab, Radiology, or Offices/Clinics and that this document shall serve as my Consent for the next year. This Consent does not apply for Inpatient Admission, Emergency Department, Urgent Care, Surgical or other procedures. If I wish to sign a new Consent upon each visit, I can request a different form at this time. If I wish to change or revoke this Consent, or if there is a change in custody, I will notify the Hospital at my next visit.

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

Signed_____ _____ _____
PATIENT, IF 18 YEARS OR OLDER DATE TIME

Signed _____ _____ _____
PARENT/GUARDIAN, IF PATIENT IS LESS THAN 18 YEARS DATE TIME

Signed_____ _____ _____
WITNESS DATE TIME

_____
PRINT NAME OF PARENT/GUARDIAN

_____ (_____) _____
STREET ADDRESS CITY STATE ZIP CODE AREA CODE PHONE NUMBER

FOR OFFICE USE ONLY - PARENTS, PLEASE DO NOT WRITE IN THIS SPACE. COMPLETE IF PATIENT IS 18 YEARS AND OLDER.

		Medical?		Mental Health?				
Advance Directives:	**Does an Advanced Directive Exist?**	**Yes_____**	**No_____**	**Yes_____**	**No_____**	**Initials_____**	**Date_____**	**Time_____**
	If yes, has actual Advance Directive document been placed in the medical record?			**Yes_____**	**No_____**	**Initials_____**	**Date_____**	**Time_____**
	If no, was AD booklet provided?			**Yes_____**	**No_____**	**Initials_____**	**Date_____**	**Time_____**

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.