Please read this document carefully. Lucile Salter Packard Children's Hospital (LPCH) requires the Terms and Conditions of Service to be signed in its entirety, without alteration.

1. **AUTHORIZED SIGNATURE.** You may sign this form only if you are a competent adult over the age of 18 or a minor who is permitted under state law to consent to treatment. If you are a minor who does not fall within the limited exceptions provided under state law or are not competent to sign this form, the form must be signed by a properly designated representative, such as a parent or legal guardian.
2. **TERM OF AGREEMENT.** The terms and conditions in this outpatient agreement will remain in effect for one year from the date of signature. You will be asked to sign this agreement annually. At each clinic visit, you will be asked to confirm that your demographic and insurance information is correct. If your insurance or demographic information has changed, please inform the clinic staff.
3. **MEDICAL CONSENT.** I, the undersigned, consent to the general treatment and procedures that may be performed during this hospitalization or as an outpatient (including emergency services). These procedures may include but are not limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services provided to the patient under the general and special instructions of the patient's physician or surgeon. I understand that it is the responsibility of the patient's physician to obtain the patient's informed consent when required for specific medical or surgical treatment and special diagnostic or therapeutic procedures. I understand and agree that at the request of the attending physician, allied health practitioners (such as physician assistants and nurse practitioners) may participate in the patient's care.
4. **TEACHING INSTITUTION.** LPCH is a teaching facility, training physicians, surgeons, nurses and other health care personnel. At the request, and under the supervision, of the attending physician, I agree that residents, interns, medical students, post-graduate fellows, visiting faculty members and other health care personnel in training may participate in the care of the patient. Certain medical services may be provided by individuals who do not have a physician's certificate but are qualified to participate in a special program as a visiting faculty member.
5. **PHOTOGRAPHY.** I consent to the taking of pictures, videotapes or other electronic reproductions of the patient's medical or surgical condition or treatment, and the use of the pictures, videotapes or electronic reproductions, for treatment or internal or external activities consistent with the Hospital's mission, such as education and research, conducted in accordance with Hospital policies.
6. **LEGAL RELATIONSHIP BETWEEN LPCH AND PHYSICIANS.** Except for those physicians under contract with LPCH, such as faculty physicians practicing in the clinics, all physicians and surgeons furnishing services to the patient are independent contractors with the patient and are not employees or agents of LPCH. The undersigned understands that the patient is under the care and supervision of his or her attending physician and that it is the responsibility of LPCH and its non-physician health care staff to carry out the instructions of such physician or surgeon.
7. **JOINT INFORMATION.** The undersigned understands that patient information and records may be shared between Stanford Hospital and Clinics and LPCH to facilitate patient care.
8. **FINANCIAL AGREEMENT.** For the services to be rendered (e.g., hospital, physician), the undersigned agrees to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of LPCH. This includes financial responsibility for all deductibles and copayments that may be required by the patient's insurance or health plan, including Medicare and Medi-cal. Should the patient's account(s) be referred to an attorney or a collection agency for collection, the undersigned further agrees to pay actual attorneys' fees and lawsuit-related expenses incurred in addition to other amounts due. When the services are to be billed to insurance, a health plan or another payment source, then paragraphs 9 (Contracted Health Plan Patients and Other Sources) and/or 10 (Assignment of Insurance Benefits) will also apply.

9. **CONTRACTED HEALTH PLAN PATIENTS AND OTHER SOURCES.** The undersigned understands that the patient may be eligible for certain health care coverage through a health plan (HMO, PPO) on the list of health plans with which LPCH contracts, or through some other source (e.g., clinical trial sponsor, employer's workers' compensation insurance). The undersigned agrees to be responsible under paragraph 8 (Financial Agreement) for paying the patient's account: (a) if LPCH does not contract with the health plan; (b) for any copayment and deductible; (c) for services not approved by the health plan or other source; or (d) for services not covered and/or paid for by the patient's health plan or other source.

10. **ASSIGNMENT OF INSURANCE BENEFITS (INCLUDING MEDICARE BENEFITS).** The undersigned authorizes direct payment to LPCH of any insurance benefits otherwise payable to or on behalf of the patient for outpatient services at a rate not to exceed the actual institutional and professional charges. The undersigned understands and agrees that he/she is financially responsible under paragraph 8 (Financial Agreement) for charges not paid in accordance with this assignment. If applicable, the undersigned further attests that information given to LPCH to assist the patient in applying for payment under the Medicare or Medical programs is correct.

The undersigned certifies that he/she has read both pages of the Outpatient Terms and Conditions of Service, has received a copy of it, and is the patient or is duly authorized by or on behalf of the patient to execute and accept its terms.

_____ _____ _____ _____

Patient or Responsible Person Signature **DOB** **Date/Time** **Witness**

Relationship to Patient: ❑ Parent With Legal Custody ❑ Patient Authorized to Consent

❑ Legal Guardian/Temporary Legal Guardian. Explain type of guardianship: _____

❑ Official documentation of guardianship/temporary guardianship received (e.g., court papers)

❑ Person with Written Authorization (e.g., Caregiver's Authorization Affidavit, Third Party Authorization, Durable Power of Attorney). Explain type of written authorization _____

❑ Documentation of written authorization received

IF INTERPRETED: _____ _____ _____

Interpreter Signature Print Name Language

_____ _____

Position/Relationship to Patient Date/Time

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE:

I agree to accept full financial responsibility for services rendered to the patient and to accept the terms of the paragraphs on Financial Agreement (8), and, if applicable, Contracted Health Plan and Other Sources (9) and Assignment of Insurance Benefits (10) above.

_____ _____ _____ _____

Financially Responsible Party Relationship to Patient Date/Time Witness

PLEASE SEE THE NOTICES REGARDING RELEASE OF INFORMATION ON THE BACK SIDE OF THIS PAGE

PLEASE EMAIL PAGE 1 AND PAGE 2 TO HIMS-LPCH@STANFORDCHILDRENS.ORG

RELEASE OF INFORMATION

In compliance with the federal privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA), Lucile Salter Packard Children's Hospital provides patients with its ***Notice of Privacy Practices,*** which describes how medical information about patients may be used and disclosed, and how patients can access this information. Copies of the Notice of Privacy Practices are available at any registration desk, in the Patient & Visitors section under Patient Services of our website www.stanfordchildrens.org or by calling the Lucile Salter Packard Children's Hospital's Privacy Office at 650-724-4722.

FINANCIAL ASSISTANCE AVAILABLE

Lucile Packard Children's Hospital has a variety of financial assistance options available to patients who are uninsured or underinsured. Lucile Packard Children's Hospital will assist patients in determining if they qualify for financial assistance or if there are programs available that may help pay for medical services. Additional information and/or a statement of charges for services provided by Lucile Packard Children's Hospital can be obtained by contacting the Customer Service Unit of Patient Financial Services at 800-549-3720.

Financial assistance applications are available at all Packard clinics and hospital registration areas. The application can also be found on our website at www.stanfordchildrens.org in the Patients and Visitors section under Financial and Insurance Information or by calling the customer service number above. Applications are reviewed to determine what assistance may be available; applicants are notified of the outcome of this review within 10 business days after the completed and signed application is received.

Patients who qualify may receive assistance with bills for services provided by Lucile Packard Children's Hospital and by physicians employed by Stanford University. Services may include inpatient and outpatient care, emergency services, co-payments and deductibles, non-covered charges, denied days and stays, and other special circumstances. Patients who have no insurance or inadequate insurance and meet certain low- and moderate- income requirements may qualify for discounted payment or charity care.