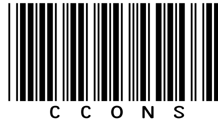

Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

PSYCHIATRY CONSENT TO EXAMINATION AND TREATMENT

I hereby give my consent for the above patient to receive psychiatric/psychological medical and/or dental examinations, treatment, and diagnostic procedures at Ann & Robert H. Lurie Children's Hospital of Chicago or at one of its affiliated locations (collectively, "Lurie Children's"). Such examinations and treatments may include, but shall not be limited to, any operation or operations or diagnostic procedures including the use of anesthesia, and the administration of blood, deemed advisable by the medical or dental staff in the exercise of their professional judgment. I understand that this consent authorizes any reasonable medical action taken for any purpose during the time the patient remains registered with Lurie Children's. I acknowledge that services may be provided by one or more of the following affiliated Providers (each of which may bill me separately): Ann & Robert H. Lurie Children's Hospital of Chicago, Pediatric Faculty Foundation, Inc., Children's Surgical Foundation, Inc., Pediatric Anesthesia Associates, Ltd., Lurie Children's Medical Group, LLC, Lurie Children's Primary Care, LLC, Almost Home Kids, and their physicians, nurses and other personnel.

I understand that Lurie Children's operates and participates in a health information exchange (the "Exchange") that facilitates the electronic sharing of medical and other individually identifiable patient health information among all health care providers that participate in the Exchange, including Lurie Children's affiliated Providers. I understand that medical information available to Exchange participants may include sensitive information relating to HIV/AIDS; Behavioral or mental health records; sexually transmitted diseases; Pregnancy; Birth control; Drug/alcohol treatment records; Genetic information; Information about sexual assault/abuse; Information about child abuse and neglect; and Domestic abuse of an adult with a disability.

I also consent to the taking of photographs, films and audio-recordings of the patient with the understanding that they are to be used for internal medical or scientific purposes only, unless I specifically consent in writing to some other use.

ASSIGNMENT OF INSURANCE BENEFITS & GUARANTEE OF PAYMENT

In consideration of any medical care provided to the above named patient, I hereby assign, transfer and set over to Lurie Children's and Providers listed above all my rights, title and interest to any and all medical reimbursement under my insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by Lurie Children's and the Providers listed above.

I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance at the current rates established by Lurie Children's and the Providers listed above for all services rendered to the above named patient from date of admission until discharge. I hereby further agree that I shall be responsible for any expense of Lurie Children's and the Providers listed above in collecting the amounts guaranteed hereby, including all court costs, reasonable attorneys' fees and all other collection expenses.

AUTHORIZATION FOR DISCLOSURE OF INFORMATION FOR HOSPITAL AND PHYSICIAN/SURGEON PAYMENT

I hereby authorize Lurie Children's and the Providers listed above to release all medical and psychiatric/psychological information that may be necessary for the payment on my behalf for the health care services rendered to the above named patient. This authorization may be revoked in writing at any time except to the extent that the actions have been taken in reliance thereon. I understand that I will be financially responsible for charges incurred for treatment if revocation or refusal to authorize the disclosure of copies of medical records or medical information results in payment denial of the insurance claim. This consent to examination and treatment, assignment of benefits, guarantee of payment and authorization for disclosure of information contained herein shall be effective beginning on the date written below and shall remain in force for a period of one (1) year from such date, or until revoked, invalidated, or updated/replaced or where Lurie Children's otherwise determines another such consent form is required.

PATIENT'S NAME ____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE ______________________________

RELATIONSHIP ______________________ DATE______________TIME ________

SIGNATURE OF PATIENT 12 YEARS OF AGE OR OVER ______________________________

DATE ______________ TIME ________

WITNESS ______________________ DATE ______________ TIME ________

INTERPRETER (as applicable) ______________________ DATE ______________ TIME ________