



Children's Hospital of The King's Daughters Health System

TREATMENT AND PAYMENT ACKNOWLEDGMENT/CONSENT

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

Consent for Treatment

I hereby request and consent to medical and/or diagnostic treatment, including admission if deemed necessary, by Children's Hospital of The King's Daughters, Incorporated ("CHKD")...

Obligation of Payment

I irrevocably direct and assign payment from my insurance company, Medicaid, Medicare, Tricare, or other provider of health care benefits to CHKDHS and/or CSG for services rendered.

Balances Due and Billing Questions

Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement.

Acknowledgments/Certifications

I, the Parent/Legal Guardian/Patient, acknowledge and certify the following:
- I received a medical screening and stabilization treatment prior to being asked about financial information while seeking care for a deemed medical emergency.
- I was provided (a) the "Patient/Family Rights & Responsibilities" and (b) the Organized Healthcare Arrangement "Notice of Privacy Practices" on the date of this Agreement...

Advance Directive to be completed if patient is an adult (18 years or older): Does the patient have an advance directive? \_\_\_ Yes \_\_\_ No

Thank you for selecting Children's Hospital of The King's Daughters Health System as your Health Care Provider

PATIENT(S) NAME (please print) DATE OF BIRTH

SIGNATURE OF PATIENT/LEGAL GUARDIAN RELATIONSHIP TO PATIENT/LEGAL AUTHORITY DATE TIME

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

For office use only:

2nd Witness: (Verbal Consent Only) Date Name of Person Accompanying Patient