THE VALLEY HOSPITAL
Ridgewood, New Jersey

Center for Child Development
Child Intake Questionnaire

Today's Date _____ **Child's Age** _____

Reason for Visit

Referring Diagnosis: _____

Patient/Parent/Caregiver Concerns: _____

_____

With which discipline is the patient scheduled? (Please check all that apply):

☐ Speech Therapy ☐ Physical Therapy ☐ Occupational Therapy ☐ Audiology

Patient Demographics

Patient's Name: _____ DOB: _____

Address: _____

Parent/Guardian Name: _____

(1) Cell phone: _____ Home phone: _____ Email Address: _____

(2) Cell phone: _____ Home phone: _____ Email Address: _____

Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Genderqueer
☐ Other ☐ Choose not to disclose

Does Birth Sex Match Gender Identity? ☐ Yes ☐ No ☐ Choose not to disclose

Sexual Orientation: *The state has mandated that everyone be asked their sexual orientation regardless of age*

☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual ☐ Other ☐ Don't know

Race: _____ Primary language: _____

Pediatrician: _____ Referring Provider (if different): _____

** **Please bring your prescription/referral to your initial appointment**

Do you currently see any of Valley's pediatric providers? ☐ Yes ☐ No

If yes, please list _____

_____

Insurance

We strongly encourage you to call your insurance company and verify your financial responsibility. Visits at our center are billed as HOSPITAL OUTPATIENT VISITS and will be subject to your deductible. If you have further questions, the Kireker Center staff will be happy to help you. Please bring your insurance card and driver's license for registration.

Primary Insurance: _____

Secondary Insurance: _____

Guarantor (Holder of Insurance): _____ Guarantor's Date of Birth: _____

Relationship to Patient: _____ Occupation: _____

Guarantor's Address: _____

☐ Check if same as patient's address.

Guarantor's Employer: _____

Employer's Address: _____

Employer's Phone Number: _____

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Birth History

Is this child legally adopted? ☐ Yes ☐ No Who is the legal guardian?_____

Is this child in foster care? ☐ Yes ☐ No Caseworker/Agency_____

Weeks of pregnancy_____ Birth Weight _____

Hospital/Place of Birth:_____

Was your pregnancy high risk? ☐ Yes ☐ No

Any complications during pregnancy or delivery? ☐ Yes ☐ No ☐ Unknown

If yes, _____

This pregnancy was:

☐ Spontaneous ☐ Achieved via assisted reproductive technology ☐ Twin ☐ Surrogacy

Were there any prenatal concerns? _____

Check all that apply:

☐ Asphyxia/lack of oxygen at birth/Assisted Ventilation ☐ Hyperbilirubinemia with exchange transfusion

☐ Jaundice ☐ Congenital or Perinatal Infection

☐ NICU If yes, length of stay_____ ☐ ECMO (extracorporeal membrane oxygenation)

☐ Zika ☐ CMV (Cytomeglovirus)

☐ Ototoxic Medications after birth (aminoglycosides: gentamicin, tobramycin, amikacin, streptomycin)

Medical History

Has your child had any surgeries or other hospitalizations? If yes, please list type and date.

☐ Surgeries_____

☐ Hospitalizations _____

Has your child had any imaging? If yes, please list type and date.

☐ MRI/CT_____ ☐ XRAY _____

☐ Other_____

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Please check all that apply:

☐ Asthma
☐ Allergies
☐ Blood Pressure_____
☐ Cardiac Issues
☐ Cancer
☐ Dizziness/imbalance
☐ Headaches
☐ Muscle Tone Concerns _____
☐ Pneumonia
☐ Serious Illness or Accidents
☐ Seizures
☐ Other _____

Current Medications (Prescribed or Over the Counter): _____

_____

_____

Developmental History

Has your child received any of the following diagnoses? Please check and provide date of diagnosis.

☐ ADHD_____
☐ Autism _____
☐ Developmental delay(s) _____
☐ Genetic disorder(s)_____
☐ Fetal Alcohol Syndrome _____
☐ Other_____

Has your child had any of the following evaluations? If yes, please provide report(s).

☐ Audiology ☐ Behavioral Assessment ☐ Early Intervention

☐ Feeding ☐ Occupational therapy ☐ Physical therapy ☐ Speech/Language

Was your child recommended for any therapies? If yes, please include frequency.

☐ Early Intervention Services

Developmental Intervention _____ Speech Therapy_____

Physical Therapy_____ Occupational Therapy_____

☐ Private Therapy

Applied Behavioral Anyalysis_____ Speech Therapy_____ Feeding Therapy_____

Physical Therapy_____ Occupational Therapy_____ Counseling Therapy_____

Has your child been seen by other professionals or had additional evaluations? (e.g., Developmental Pediatrician, Orthopedist, Child Psychologist, etc.) ☐Yes ☐No

If yes, please describe: _____

_____

Center for Child Development
Child Intake Questionnaire

At what age did your child perform the following skills?

Roll back to belly: _____ Roll belly to back: _____

Sit unsupported: _____ Crawl: _____

Pull to stand: _____ Walk: _____

Drink from a cup: _____ Finger feed: _____

Babble (speech): _____ First words: _____

Combine words: _____ Use Sentences: _____

Has the child completed vision screening? ☐ Yes ☐ No

Results: _____ Glasses use: ☐ Yes ☐ No

Hand Preference: ☐ Left ☐ Right ☐ Other _____

Behaviors and Characteristics: Please indicate if your child exhibits any of the following:

☐ Sensitive to loud sounds (covers ears)
☐ Short attention span
☐ Aversion to touch, taste, smell, light (if yes, please explain) _____
☐ Easily frustrated
☐ Difficulty following directions
☐ Impulsive
☐ Hyperactivity
☐ Disruptive
☐ Daydreams
☐ Tires easily
☐ Difficulty falling or staying asleep _____
☐ Difficulty socializing with same age peer
☐ Difficulty expressing ideas
☐ Forgetful
☐ Displays repetitive behaviors _____
☐ Difficulty hearing in noisy places
☐ Asks for repetition, says "huh?" or "what?"
☐ Spelling problems
☐ Dislikes school
☐ Frequent temper tantrums
☐ Fidgety/trouble sitting still
☐ Other _____

_____

Center for Child Development
Child Intake Questionnaire

Social / Educational History

Patient lives with:

_____

Patient's school/daycare: _____ Grade: _____

List any Social/Academic Difficulties _____

_____

Does your child receive any support or accommodations at school?

☐ 1:1 Aide ☐ 504 ☐ IEP ☐ Pull out for small group learning. Reading____ Math ____

☐ Other _____

Additional Information

Is there an open case with the Department of Child Protective Services ☐Yes ☐No

Is your child registered for PerformCare? ☐Yes ☐No

Are there any other things you would like to tell us about your child?

_____

_____

_____

_____

Feeding evaluations ONLY please complete the following:

Feeding History

Have you ever had a feeding evaluation completed before? ☐Yes ☐No

Was feeding therapy recommended for your child? ☐Yes ☐No

Where: _____

When: _____

Problems during feeding:

☐ Choking ☐ Coughing ☐ Crying
☐ Nasal Regurgitation ☐ Vomiting ☐ Slow Feeding
☐ Reflux ☐ Gagging ☐ Food Refusal/ Limited intake
☐ Other (please describe): _____

Food Allergies:

☐ Milk protein allergy

☐ Other food allergies _____

_____

Mealtime/Feeding Behaviors:

Position for feeding: _____

Utensils/bottles used: _____

Number of meals daily: _____

Amount taken at each meal: _____

Has your child maintained the growth curve for height and weight? ☐Yes ☐No

If no, _____

Are you concerned about your child's bowel movements? ☐Yes ☐No

If yes, _____

In advance of your appointment please complete a diet log.

Please keep a 3-day diet log. If your child's feeding schedule changes from weekday to weekend (e.g.: daycare vs. home), please keep a 2-weekday diet log and a 2-weekend diet log. Please include the following information:

1. Time feeding began and time feeding ended
2. Food and drink provided and how much was consumed
3. Who was the feeder?
4. Observations of the feeder (e.g.: gagging, coughing, choking, vomiting etc.)

***On the day of the feeding evaluation, please bring a variety of preferred food and drink as well as a variety of items that are being refused. This will allow us to gain a holistic picture of your child's feeding and/or swallowing difficulties.**

Center for Child Development
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Audiology evaluations ONLY please complete the following:

Audiological History

Do you have concerns about your child's hearing? ☐ Yes ☐ No

Check all that apply:

☐ Ear pain

☐ Ear infections (explain) _____

☐ Ear Tubes (explain) _____

☐ Pulls or tugs on ears

☐ Family history of permanent childhood hearing loss _____

☐ Other _____

Previous Hearing Test Completed (not including newborn or routine screening): ☐ Yes ☐ No

When _____

Where _____

Does your child wear hearing aids ☐ Yes ☐ No If yes, explain: _____

_____

_____

_____

Cancellation/Attendance Policy

Children cannot be left unattended in the waiting room. A parent/caregiver/designee must always remain in the center when the child is receiving services.

If you are unable to keep an appointment, please call 201-612-1006 in advance to cancel.

If two (2) consecutive appointments are missed without prior cancellation OR if 50% or more visits are missed in a two (2) month period, therapy will be discontinued.

We reserve the right to charge for No Shows. Be advised that your insurance company will not reimburse for any no show appointments.

Communication and Medical Record Requests

Communications via email will be encrypted in order to safeguard Protected Health Information ("PHI") unless the patient or personal representative requests otherwise.

The therapy plan of care will be sent to the referring physician. You can access the medical records by a formal request via the link below or without delay via the patient portal. The staff are not able to provide you with copies of medical records. More information regarding accessing the portal will be provided based on the patient's age.

All other medical record requests can be completed via this link:
https://www.valleyhealth.com/patients-visitors/health-information-management

Print Name Patient/Representative: _____ Relationship: _____

Patient/Representative Signature: _____

Date: _____ Time: _____

Print Therapist Name: _____ Date: _____ Time: _____

Therapist Signature: _____

General Informed Consent for Hospital Care Services (Inpatient, Outpatient, & Emergency Services)

1. **CONSENT TO CARE:** I consent to treatment at The Valley Hospital (the "Hospital") as an inpatient and/or outpatient, depending on my medical needs. I have verified all demographic information on my Admission Form and Hospital identification band are correct. I consent to treatment by the Hospital Medical Staff, Hospital employees, independent contractors and/or agents. I understand my care may include routine diagnostic tests (such as blood work, buccal swabs), examinations, anesthesia, and medical and surgical treatments. No guarantees have been made to me about the outcome of my care. I agree that treatment may be provided in person or, as applicable, via a secure and HIPAA compliant telecommunications platform. I acknowledge the Hospital's authority to obtain and dispose of specimens taken for laboratory or pathology examination according to its usual procedures. I understand the Hospital participates in various health care education programs and students may participate in my care or treatment and I may decline care provided by students.

2. **NURSING CARE:** I understand the Hospital will provide general duty nursing care consistent with my medical needs. If I wish to have nursing care beyond what the Hospital deems necessary and appropriate, I may do so at my own cost and must directly arrange for this care.

3. **PATIENT RIGHTS/IMPORTANT NOTICES:** I acknowledge I have been provided a copy of the following: (i) Hospital and Ambulatory Care Facility Patient Bill of Rights, (ii) information about my Right to make Health Care Decisions, including Advance Directives, (iii) information about my Rights and Protections Against Surprise Medical Bills. I agree I may receive these copies electronically and acknowledge any electronic copies can be found in my Patient Portal account. I have a right to request a paper copy and may request a paper copy from a staff member at any time.

4. **IMAGES:** I consent to the use of photography or videotaping relating to my medical condition. I understand any images may be used for my treatment and/or medical education. I understand recording and/or monitoring devices may be utilized in patient rooms to capture images and provide notifications/alerts to staff to assist with the delivery of patient care services and support efforts to maintain patient safety. These images, by design, make the individual unrecognizable and are not a part of the medical record. The Hospital will protect the confidentiality of my images in accordance with all applicable federal and state privacy laws.

5. **VACCINATIONS:** I understand the Hospital may offer certain vaccinations, but I may decline any vaccination offered to me.

6. **PATIENT PROPERTY:** I understand the Hospital is not liable for the loss of or damage to any of my personal property, including, but not limited to: cell phones, computers, money, jewelry, documents, or other articles of value, unless deposited with the Hospital for safekeeping. I understand no employee or agent of the Hospital has the authority to increase the Hospital's liability for my personal property.

7. **RELEASE OF INFORMATION:** I understand Valley Health System, Inc. and affiliated entities including The Valley Hospital, Valley Medical Group and Valley Home Care, Inc., and their employees, medical staff, independent contractors and/or agents (collectively, and as applicable, "Valley"), may receive, have access to, use and disclose my medical information and billing information ("Medical Information") as described in this Consent and the Valley Notice of Privacy Practices.

Type of Information. Medical Information includes, as applicable, my diagnosis, prognosis, treatment received, diagnostic tests, images and procedures performed, medication history, and other information about my medical care which may be maintained now or in the future. I understand my Medical Information which may be shared under this Consent may also include sensitive information, if any, regarding my past, present and future behavioral and mental health, HIV/AIDS related information, sexually transmitted diseases, tuberculosis, genetic information, including genetic test results, drug or alcohol related illness, any communication or information regarding reproductive health services information, or emancipated care I may receive as a minor, unless a separate written consent from this form would be required by applicable law.

Purpose/Recipients. I understand and agree my Medical Information described above may be accessed, used and disclosed (shared) in order to carry out treatment, payment or health care operations, and other purposes permitted or required by law, including post discharge coordination of my care, as described in the Valley Notice of Privacy Practices. The Hospital may release my Medical Information to or receive information for these purposes from my former, current or future health care providers, my insurance companies/payors, including Medicare or Medicaid or any other person or

entity that may be responsible for coordinating my health care or paying any portion of my bill for services. If I am a minor permitted by applicable law to independently consent to treatment, I understand that certain information may be disclosed to my parent(s) or guardian(s) such as for payment purposes, to obtain authorization for medication I may be prescribed to the extent such authorization is required by applicable law or as otherwise permitted.

I understand and agree sharing of my Medical Information may be facilitated through electronic health information exchange entities such as the New Jersey Health Information Network, CommonWell, and their participants (collectively, "Health Information Exchanges" or "HIEs"). I understand the Valley Notice of Privacy Practices sets forth additional information about HIEs, including how I can opt-out of participating in such HIEs. I acknowledge this Consent serves as notice to me of the recipients who may have access to, use and disclose my Medical Information. I also understand my consent is revocable at any time by writing to the Valley Privacy Officer as identified in the Valley Notice of Privacy Practices, except to the extent action has already been taken in reliance on my consent. This Consent will remain in effect for a reasonable time in order to accomplish the purposes for which it is given.

8. **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:** I acknowledge I have been provided a copy of the Valley Notice of Privacy Practices and was given an opportunity to ask questions and voice concerns. I agree I may receive this electronically and acknowledge the electronic copy can be found in my Patient Portal account. I have a right to request a paper copy and may request a paper copy from a staff member at any time. I hereby consent to the uses and disclosure of my Medical Information set forth in the Valley Notice of Privacy Practices.

9. **COMMUNICATION:** I agree Valley, all Hospital-based physicians/providers, and any entity conducting billing, collection and other activities related to the services I receive, may contact me at the email addresses and telephone numbers I provide or which are obtained through other means (whether landline, mobile/cellular or other device) for any lawful purpose. This includes but is not limited to contacting me with health care related communications such as appointment reminders, instructions, quality or treatment initiatives, test results or survey requests, as well as to bill or obtain payment or to request I provide feedback or reviews regarding my care. I agree the means by which I may be contacted include live operator, email, auto-dial, text/SMS/multi-factor authentication messages or artificial/pre-recorded messages, as applicable. I understand standard telecommunications carrier message and data rates may apply and I should contact my carrier for these rates. Message frequency may vary. I may opt out or unsubscribe from certain communications by sending a writing to the address provided in the Valley Notice of Privacy Practices, or in accordance with instructions provided to me for a particular communication.

IMPORTANT NOTICE REGARDING MEDICAL PROVIDERS

I understand the physicians or other providers involved in my care may NOT be Hospital employees or agents, but instead independent contractors granted the privilege to use the Hospital's facilities. Independent contractors are responsible for their own actions and the Hospital is not liable for their acts or omissions. I understand any physician or some providers who treat me at the Hospital may not participate in or accept the same insurance or health care plans as Valley, so I may be balance billed, if permitted by applicable law. I understand professional services fees are billed separately from Hospital charges, and I am responsible for payment of both Hospital charges and professional services fees not covered by my health insurer or other payor.

ADVANCE DIRECTIVES AND/OR POLST (PATIENTS 18 OR OVER ONLY)

I have an **Advance Directive and/or Medical Power of Attorney:** ☐ YES ☐ NO ☐ UNKNOWN **If YES, please check one:**	I have **Practitioner Orders for life-Sustaining Treatment:** ☐ YES ☐ NO ☐ UNKNOWN **If YES, please check one:**
☐ A new copy is provided for the medical record. ☐ A copy is on file from a prior admission or treatment and should be used unless modified or revoked. ☐ A copy will be provided for the medical record.	☐ A new copy is provided for the medical record. ☐ A copy is on file from a prior admission or treatment and should be used unless modified or revoked. ☐ A copy will be provided for the medical record.

General Informed Consent for Hospital Care Services (Inpatient, Outpatient, & Emergency Services)

PATIENT DIRECTORY

☐ **UNRESTRICTED:** I want my name, location and general condition to be included in the Patient Directory during my stay or visit at the Hospital (inpatient, emergency department, observation or outpatient). I understand this information will be available to those who ask for me by name, such as relatives, friends or entities assisting with disaster relief efforts, so that family, friends and other individuals can locate me at the Hospital. I also want my religious and congregational affiliation, if any, to be included and understand this information may be given to clergy or representatives of my congregation.

☐ **RESTRICTED: I want to restrict my information and/or visitors as follows (please check all that apply):**

- ☐ I want to be listed in the Patient Directory as "Confidential" and understand this designation means **ALL** visitors and callers will be told the Hospital has **NO** information about me and **NO** visitor passes will be issued.
- ☐ I do not want my religious or congregational affiliation shared with outside clergy or my congregation.
- ☐ I want to limit my visitors and the names of any restricted visitors have been given to Hospital Security.

I CERTIFY I HAVE READ AND UNDERSTAND THIS GENERAL INFORMED CONSENT TO HOSPITAL CARE SERVICES. I HAVE HAD THE OPPORTUNITY TO ASK AND HAVE HAD ANSWERED ANY QUESTIONS TO MY SATISFACTION, AND I FURTHER AGREE TO THE TERMS OF THIS CONSENT.

Signature of Patient or Patient's Authorized Representative _____ Date _____ Time _____

Only if Patient is unable to consent, complete the following:

Name of Patient's Authorized Representative _____ Relationship to Patient _____

Reason Patient Cannot Consent _____

Name of Witness _____ Signature of Witness _____

THE VALLEY HOSPITAL
Ridgewood, New Jersey

Financial Authorization and Assignment of Benefits

I. AGREEMENT TO PAY FOR SERVICES AND ASSIGNMENT OF REIMBURSEMENT BENEFITS

In consideration of the services rendered to me at or by The Valley Hospital (the "Hospital"), I hereby agree to pay the Hospital and all Hospital-based physicians/providers providing services to me, the entire amount due for all services I receive. I hereby assign to the Hospital and all Hospital-based physicians/providers providing services to me all rights, title and interests that I may have to receive payment from a health insurer or other payor for services rendered by the Hospital, including those which otherwise may be payable to me. I authorize and consent to the Hospital and its representatives appealing, on my behalf, any utilization management determination made by my HMO, insurance company or a designated review agency, which results in a denial, termination, or other limitation of covered health care services, and/or to file a formal complaint on my behalf with the State Consumer Protection Department of Insurance to secure payment.

I understand that I am responsible for and will promptly pay all amounts not paid by my insurance, such as co-payment, deductibles and any charges that my insurance will not cover, to the fullest extent permitted by law, unless arranged otherwise with the Hospital. This includes services which I choose to receive even though my health insurer or payor has not, through its review process, approved the provision of such services. I agree to pay the Hospital for all non-covered charges, including, but not limited to, telephone, television and any private room differential. I will refer to the rates for service provided by the Hospital and all Hospital-based physicians/providers for the maximum dollar amounts that I may be required to pay.

I further understand that any recovery of a monetary settlement resulting from my present illness or injury from insurance, litigation or otherwise will first be applied toward payment of the cost of my care. If the amount of such settlement received by the Hospital is less than the value of its services, as set forth in the bill(s) rendered to me, I will pay the difference between the amount of such settlement and the total bill for Hospital services.

II. MEDICARE AND MEDICAID

If applicable to me, I certify that the information given by me in applying for payment under Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act is correct. I consent to the release of all records required to act on this request for payment. If I have Medicare Part A benefits, I understand that Medicare payments will be accepted as payment in full and I will have no financial liability, other than applicable co-payments and deductibles, unless I have been notified in writing that service(s) will not be covered by Medicare and I still wish to receive the care or service. I understand that while I am under the Hospital's plan of care, the Hospital will coordinate all medically necessary therapy services and medical supplies for me. If I arrange for these services or supplies on my own, I understand that Medicare will not reimburse me or my supplier and I will be responsible for the total cost. I request that payment of authorized benefits from Medicare or other responsible payor be made on my behalf to the Hospital. I hereby assign and the Hospital accepts assignment of benefits from Medicare and Medicaid. If applicable to me.

III. INSURANCE AUTHORIZATION

I understand that my commercial health insurer or payor may require me or my doctor to obtain precertification, pre-authorization, admission notification review or a second opinion prior to obtaining Hospital services, Emergency Room treatment and/or admission. I understand that it is my responsibility to obtain all such authorizations and that failure to do so may result in a reduction, denial, or other limitation of covered health care services for which I may be liable. I also understand that the services must be, as defined by my insurance company, medically appropriate or necessary to be considered for payment.

I also understand that my insurance will cover only the dependents listed under my insurance policy. Newborns or dependents **must be added** to the insurance policy to be covered (time frame is dependent on your insurance carrier). You must call your insurance to confirm the dependent coverage.

Financial Authorization and Assignment of Benefits

IV. ADDITIONAL BILLS

In addition to your bill from the Hospital, you may receive other bills for services rendered during your inpatient stay or outpatient/Same Day service for an interpretation of an exam or for a physician/provider professional component. These bills will be mailed to you separately and are not part of the charges incurred for your hospital stay or outpatient service. Please refer to the Hospital's "Important Notice to Our Patients about Insurance Coverage."

V. RELEASE OF PATIENT RECORDS AND INFORMATION FOR PAYMENT

I authorize and consent to the access, use and disclosure of my medical and billing information for payment and health care operations purposes ("Medical Information") by the Hospital, Hospital-based physicians/providers, and any person or entity performing billing and related services for the Hospital or Hospital-based physicians/providers. I understand that my Medical Information may include, as applicable, my diagnosis, prognosis, treatment received, diagnostic tests, images and procedures performed, medication history, and other information about my medical care which may be maintained now or in the future. I understand that my Medical Information may also include sensitive information regarding my past, present and future behavioral and mental health, HIV/AIDS information, sexually transmitted diseases, tuberculosis, genetic information, including genetic test results, or drug or alcohol related illness, unless a separate written consent from this form would be required by applicable law.

Use and disclosure of my Medical Information may be made by or to my health plan, insurer, or other person or corporation identified by me or which is or may be liable for services rendered by the Hospital or Hospital-based physicians/providers for all or part of their charges. Use and disclosure may also be made by and to my spouse, hospital or medical service companies, my employer, my HMOs, insurance companies, workers' compensation carriers, welfare fund or government agencies.

I understand that this consent is revocable at any time, except to the extent that action has been taken in reliance upon this authorization, by contacting the Valley Privacy Officer, as identified in the Notice of Privacy Practices.

MEDICARE BENEFICIARY (IF APPLICABLE)

☐ I am a Medicare Beneficiary receiving inpatient care and have received a copy of the notice, "AN IMPORTANT MESSAGE FROM MEDICARE." My signature only acknowledges my receipt of this message from the Hospital and does not waive any of my rights. I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me by or in the Hospital, including physician/provider services. I authorize any holder of Medical Information or other information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services.

I certify that I have read and that I understand this authorization. I HAVE HAD THE OPPORTUNITY TO ASK AND HAVE HAD ANSWERED ANY QUESTIONS TO MY SATISFACTION, AND I FURTHER AGREE TO THE TERMS OF THIS FINANCIAL CONSENT.

This Financial Consent will remain in effect for a reasonable time in order to accomplish the purposes described above for which it is given.

Date: _____ Time: _____

_____
Patient's or Authorized Representative Signature

Patient is unable to consent because: _____

_____

_____
Witness to Signature(s)

_____
Name of Person Signing/Relationship to Patient (Print in Caps)

THIS AUTHORIZATION IS RETAINED BY THE BUSINESS OFFICE

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care-like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact The Department of Health and Human Services' No Surprises Help Desk: 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumer for more information about your rights under federal law.