Saint Thomas Medical Partners

Saint Thomas Medical Partners Maplewood H.S.

Registration and Consent to Treat Forms

School Year __________________

THIS FORM IS TO BE FILLED OUT IN IT'S ENTIRITY, SIGNED IN INK AND RETURNED TO YOUR SCHOOL

(Services will not be provided to children under age 18 without parental consent as required by Tennessee Law)

PLEASE PRINT

Student's/Patient Name: ______________________________ Patient Date of Birth: __________________________

Patient SSN: _______________________________________ Gender: Male Female Transgender

Address: ____

City: ____________________________ State: ________________ Zip:_______________

Phone Number (Home): _____________________________ Cell:____

E-Mail: ____

Do you want to be enrolled in the patient portal? ☐ Yes ☐ No

Need Interpreter: ☐ Yes ☐ No Patient Language: ____

Housing Situation (Check one):

☐At risk for homelessness
☐Currently not homeless, was in last 12 months
☐Homeless, unknown shelter
☐Living in Shelter
☐Living with others
☐Not homeless
☐Street, camp, bridge
☐Transitional housing

Race:

☐Alaskan Native
☐American Indian
☐Asian
☐Black
☐White
☐Native Hawaiian
☐Unknown
☐Patient refused

Migrant Seasonal: ☐ Migrant ☐ Seasonal ☐ Neither Veteran Status: ☐ Yes ☐ No

Ethnicity (check one): ☐ Hispanic ☐Non-Hispanic ☐Not collected/Unknown ☐Patient Refused

Emergency contact:_________________________________ Phone: __________________ Relationship: _____________

Number of people who live in your home:_________ Total Household Income:________ Monthly or Annual (circle one)

Guarantor Name:____ Date of Birth: _______________________

Guarantor SSN: ____ Gender: Male Female Transgender

Address: ____

City:_______________________ State: _____________ Zip: __________ Phone: ____________________________

Does the patient have insurance and/or Medicaid? ☐ Yes ☐ No If yes, complete all fields.

Primary Insurance/Medicaid: ____

Subscriber Name_________________________ Subscriber Date of Birth: ______________________
Relationship to Patient: ____________________ Subscriber SSN: ______________________________
Subscriber ID: ___________________________ Group Number: _______________________________

Do you have secondary insurance and/or Medicaid? ☐ Yes ☐ No If yes, complete all fields.

Secondary Insurance Medicaid: ____

Subscriber Name_________________________ Subscriber Date of Birth: ______________________
Relationship to Patient: ____________________ Subscriber SSN: ______________________________
Subscriber ID: ___________________________ Group Number: _______________________________

I give consent for this patient to receive health care services and necessary medication from the staff at Saint Thomas Medical Partners. I understand that the health care services include routine and preventive health care services such as:

- General health assessments
- Immunizations
- Evaluations, diagnosis, treatment for acute illness and injuries
- Prescription of and administration of medications
- Management of long term illnesses (example: asthma)
- Evaluation, diagnosis, treatment of Behavioral Health issues, Psycho educational and psychological assessments
- Health education and individual and/or group counseling

I authorize information to be shared between Saint Thomas Medical Partners, the staff of my child's school (if applicable), my child's primary health care provider, and my child's insurance provider (in applicable).

For my child: I give consent to Saint Thomas Medical Partners to look over my child's full school records, including attendance and other information that may assist the staff in helping my child. I understand that this consent will allow my child to receive health services for the current year and to transport medication prescribed by the staff unless I change my mind by writing a letter to the clinic. I understand that it is my responsibility to notify the clinic about changes in guardianship, address, and phone number.

I acknowledge that I am aware of and can request a copy of Saint Thomas Medical Partners Notice of Privacy Practices. This notice is also posted inside each Saint Thomas Medical Partners practice.

Signature:___________________________________ Witness: ______________________________ Date: ________

Patient Consent Agreement

This Patient Consent Agreement applies to services provided by Saint Thomas Medical Partners.

Medical Treatment

I request or authorize Saint Thomas Medical Partners to provide and perform under the direction of my provider(s) and/or his/her designee such care, procedures, services and supplies as are considered advisable for my health and well-being. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me by my provider(s) or Saint Thomas Medical Partners. I understand that it is the responsibility of the provider to explain to me the nature of any diagnosis, therapeutic, medical, and/or surgical procedures necessary to treat me and to explain risks and consequences associated with the services.

I authorize Saint Thomas Medical Partners to dispose any tissue, severed or amputated member, body part, or medical devise removed in connection with the services provided by Saint Thomas Medical Partners,

Patient Rights and Advance Directives

If I am receiving hospital in-services, ambulatory outpatient services, ambulatory surgical center services or home health services, I acknowledge I have been given written materials on my patient rights and responsibilities, which include my right to an advance directive, For all other community services, I understand that information about advance directives is available upon request.

Consent to Release Medical Records

I understand Saint Thomas Medical Partners will make every effort to treat my medical record information as confidential, however, I realize information must be shared with other providers involved in my care or in the payment of my care. I consent to the release of my medical information for treatment, payment and health care operational purposed as allowed by State and Federal law, including the release of communicable disease information.

Federal regulations and State laws protect confidentiality of hospitalization or treatment information regarding alcohol abuse, substance abuse, mental health treatment or counseling, communicable disease documentation, and human immunodeficiency virus (HIV). Saint Thomas Medical Partners integrated medical and behavioral care services that are charted in a shared electronic medical record. I understand that my consenting to treatment at Saint Thomas Medical Partners, I am also consenting to the sharing of the aforementioned information among all providers.

Legal Relationships

I understand my services may be provided by (1) health care providers who are not employees of Saint Thomas Medical Partners, but who have a contract with Saint Thomas Medical Partners to provide services such as residents, radiologists, lab services and other independent providers; and (2) health care providers who have no employment or other contractual relationship with Saint Thomas Medical Partners; and these partners may or may not participate in my insurance plan. I understand Saint Thomas Medical Partners is responsible for carrying out the instructions of such providers, but I acknowledge (a) such providers are not employees or agents of Saint Thomas Medical Partners; and (b) **Saint Thomas Medical Partners is not responsible for the medical decision, acts or omissions of such providers,**

Assignment of Insurance Benefits

I assign payment to : (1) Saint Thomas Medical Partners; (2) health care providers who are not employees of Saint Thomas Medical Partners, but who have a contract with Saint Thomas Medical Partners to provide services such as residents, radiologists, and lab services; and (3) health care providers who have no employment or contractual relationship with Saint Thomas Medical Partners. I understand I will receive separate bills for services ordered or rendered by providers who are not employees of Saint Thomas Medical Partners and who may not participate in my insurance plan.

I understand Saint Thomas Medical Partners verifies my benefits and/or bills my insurance company as a courtesy to me. I authorize Saint Thomas Medical Partners to release to Medicare and its agents any information needed to determine my benefits for services received. I authorize the release of my medical records and any other information necessary to obtain payment from Medicare, Medicaid, and other payers. I request that payment of authorized benefits from Medicare, Medicaid, and other payers be made on my behalf to Saint Thomas Medical Partners for services provided by Saint Thomas Medical Partners. This assignment does not apply to patients with insurance that is not accepted by Saint Thomas Medical Partners.

Assignment of Insurance Benefits (continued)
Further, I understand that verification of my benefits is not a guarantee the insurance company will pay those benefits and I am responsible for ensuring that any prior authorization required for my services is obtained in advance of treatment, In addition, I hereby appoint Saint Thomas Medical Partners and its employees and agents as my representative to file grievances and appeals for me with my insurance plan/HMO as allowed by Tennessee State Law.

Responsibility for Payment
I understand that I may request and receive an estimate of anticipated charges. I understand and acknowledge that an estimate is not a guarantee that the estimate is not binding upon Saint Thomas Medical Partners; and that actual charges will be determined based on the services I receive and may be more or less than the estimate. I understand that I am financially responsible for all amounts not paid by insurance or other payers for services provided to me by Saint Thomas Medical Partners and I agree to pay all charges when due or in accordance with any financial arrangement made at the time of discharge.

I understand Saint Thomas Medical Partners provides a charity care assistance program for those who qualify. I financial documents may be required to qualify for this program.

Statement of Association
Saint Thomas Medical Partners uses AthenaNet as their electronic medical record system. Patient hereby authorizes the electronic transfer of information contained in a patient's medical record to specific third parties. The patient's express authorization permits medical records to be release dot the following parties: insurance companies, government agencies and other health care third parties.

Receipt of Notice of Privacy Practices
I acknowledge that I have been presented with the Saint Thomas Medical Partners' Notice of Privacy Practices and understand that I can request a copy at any time.

I acknowledge that I have read and agree to the Patient Consent Agreement and understand that I can request a copy of this document.

____	_________	___________________________
Patient/Legal Representative Signature	Date	Relationship (if not parent)
____	_________	___________________________
Guarantor Signature (if other than parent/legal representation	Date	Relationship
____	_________	___________________________
Witness	Date	Time