UR MEDICINE
MEDICINE of the HIGHEST ORDER

To parent or guardian,

Please sign the enclosed paperwork and return to school nurse or Health office so this can be faxed back to us.

If you prefer to fax these documents to us, the fax number is: (585)461-1231.

This provides yearly consent for our staff to provide care via Telemedicine to your child in school. This is signed at the beginning of each year. We will still call you to gain verbal consent for each individual visit.

The form for Release of Information allows us to exchange information regarding our child's Telemedicine visits with your child's school nurse and/or pediatrician. This is a voluntary consent.

If you have any questions please do not hesitate to contact the Golisano Children's Hospital Pediatric Practice Telemedicine Coordinator at (585)275-7591.

Thank you!

HIGHLAND HOSPITAL
FF THOMPSON HOSPITAL
STRONG MEMORIAL HOSPITAL

TELEHEALTH CONSENT

SH 419TELE MR

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RR DONNELLEY

This consent is for all telehealth services provided for the following condition(s): Pediatric Chronic & Acute Illness .

1. I understand that my health care provider wishes me to engage in a telehealth appointment/consultation to evaluate my health condition.

2. My health care provider has explained to me that either video conferencing technology and/or electronic transmission of my health information such as radiologic images, photos and sounds will be used during this appointment/consultation and it will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand that there are risks associated with use of this technology such as interruptions, technical difficulties, and inability to obtain information sufficient for decision making about my health problem and that all possible precautions will be taken to minimize these risks. In addition, my health care provider or I can discontinue the telehealth visit if it is felt that the information obtained through the telemedicine connection is not adequate for diagnostic decision-making or for implementing management of my health problem. In that event, we will endeavor to facilitate access to a site where adequate care can be provided, such as a doctor's office or other source of in-person care.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the appointment/consultation and thus will have the right to request the following: (a) Omitting specific details of my medical history/physical examination that are personally sensitive;
(b) Asking non-medical personnel to leave the telemedicine examination room; and/or
(c) Terminating the consultation at any time.

5. The alternatives to a telehealth appointment/consultation have been explained to me. In choosing to participate in a telehealth appointment/consultation, I understand that some parts of the visit, such as the physical exam, may be conducted by individuals at my location at the direction of the consulting health care provider, as indicated.

6. In an **emergent** consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7. I understand that depending on factors such as my location, my health insurance, and the services I am receiving, billing may occur from both my health care provider and the facility at which I am presenting for my appointment. If my health insurance is Medicaid and I am receiving telepsychiatry services in a location that is licensed by the New York State Office of Mental Health, I understand that billing will only occur from the facility at which I am presenting.

8. I have had a direct conversation with my health care provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify that:

- I have read or had this form read and/or had this form explained to me
- I fully understand its contents including the risks and benefits of the telehealth appointment/consultation
- I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction.
- I consent to this telehealth appointment/consultation.
- I have been provided with the University of Rochester Medical Center and Affiliates Notice of Privacy Practices.

Patient/Parent/Guardian Signature	Date	Time

TO BE COMPLETED BY STAFF
No signature was obtained due to:

○ Impractical, verbal consent given
○ Patient's condition/capacity
○ No representative

Staff Signature	Date	Time

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UNIVERSITY of ROCHESTER MEDICAL CENTER
& Affiliates

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Strong Memorial Hospital
Department or Practice _____
601 Elmwood Avenue, Box #: _____
Rochester, NY 14642
Phone: (585) _____ Fax: (585) _____

RR DONNELLEY

SH 48 Authorization for Release/Disclosure of Medical and/or Behavioral Health Information

PLEASE PRINT:
Patient name: _____ Date of Birth: _____
Address: _____ Patient's phone#: ( )_____
City/State/Zip: _____

This Authorization allows URMC & Affiliates to: (check one or both)

☐ **SEND** copies of your record to (or discuss your information with) the provider/person/facility below

☐ **RECEIVE** copies of your record from (or discuss your information with) the provider/person/facility below

Mary Cariola
Name of Provider/ Person/Facility _____ Address _____

City, State, Zip Code _____ Phone #/Fax # (include area code) _____

PURPOSE FOR THIS REQUEST: ☐ Healthcare or Appointment **(date)** _____ ☐ Insurance ☐ Other

TYPE OF RECORDS or INFORMATION REQUESTED: Check all that apply: **Telemedicine**

The records requested are to include: ☐ Mental Health Treatment Records ☐ Alcohol/Drug Treatment Records
(Release/disclosure of HIV-related information requires additional authorization on form NYS DOH2557 or OCA 960)

☐ **Inpatient admission(s)/date(s):** _____
(Check only **one** of the following 3 choices if requesting inpatient records)
- ☐ Treatment summary (includes discharge summary, history/physical, laboratory tests, x-ray reports, operative reports, pathology)
- ☐ Specific information or reports (describe): _____
- ☐ Other (describe): _____

☐ **Outpatient/Office visits--date(s):** _____ **and/or specific illness/injury:** _____.
(Check type of outpatient visit to be released)
☐ Clinic/doctor/dental visit ☐ Ambulatory Surgery visit ☐ Emergency Department Record
☐ Radiology report(s) ☐ Laboratory test results ☐ Immunizations ☐ Physical/occupational therapy record(s)
☐ Other (describe): Telemedicine Visit

AUTHORIZATION VALID FOR: (If nothing is checked below, this authorization is valid for this request only.)
☐ This request only
☐ One year from the date of this authorization **OR** _____ (insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.
☐ This request **and** for medical records of any **future** treatment of the type described above until: _____(insert date)

I understand that:
- My right to healthcare treatment is not conditioned on this authorization, except in very limited circumstances (e.g. non-emergent mental health or chemical dependency treatment).
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed, except that chemical dependency treatment records protected by Federal Confidentiality Rules 42CFR Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations.
- There may be a charge for the requested records.
- The medical records requested above may be faxed in cases of medical necessity.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if Representative)* _____

UR MEDICINE | STRONG MEMORIAL HOSPITAL

☐ Inpatient
☐ Outpatient
☐ ED

PATIENT CARE AGREEMENT
SMH 660 MR

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RR DONNELLEY

By signing below, I agree to the following for all care provided by this facility or by my treating professionals:

1. **Treatment Authorization.** If I am the patient, I consent to procedures and care, including photographs or recordings, my treating professionals recommend for me. If I am signing for a patient who is unable to consent, I consent to procedures and care, including photographs or recordings, the patient's professionals recommend. If asked, I will document that I am authorized to consent for the patient.
2. **Release of Medical Information.** This facility and my treating professionals may use and disclose patient health information for treatment, payment and health care operations. I authorize release of this information to government agencies (such as Medicare and Medicaid), insurance carriers, health plans, utilization review agents, home care, assisted living, nursing homes and primary care providers.
3. **Financial Responsibility.** I will pay for all hospital and professional care provided. If the bill is not timely paid I will be liable for collection fees, legal fees, court costs and interest. The institution reserves the right to bring this matter to a collection agency for non-payment.
4. **Third Party Payors.** I will promptly provide information about potential health, workers compensation, no-fault and liability insurance. I authorize this facility and my treating professionals to bill payors for all care. I assign my claim for medical benefits and payment to this facility and my treating professionals. If a claim deadline is missed because I did not provide timely information, I will pay for the care even if it would have been covered.
5. **Medicaid and Other Assistance.** If I cannot pay, this facility's financial counselors may help me qualify for Medicaid or other assistance. I will assist with the application and provide needed information. My application may be denied if I do not provide needed information in time.
6. **Financial Assistance.** This facility has a Financial Assistance program for eligible persons who do not have insurance or cannot pay their bills. To be considered for Financial Assistance, I may need to apply for Medicaid and meet other requirements. (Call (585) 784-8889 for more information).
7. **No Fault Assignment.** I HEREBY ASSIGN TO THIS FACILITY AND MY TREATING PROFESSIONALS ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW. THIS AGREEMENT SHALL BECOME NULL AND VOID IF AT ANY TIME IT IS DETERMINED THAT BENEFITS ARE NOT PAYABLE DUE TO THE FOLLOWING CIRCUMSTANCES: LACK OF COVERAGE, VIOLATION OF A POLICY CONDITION, OR DETERMINATION THAT THE TREATMENTS/SERVICES RENDERED ARE NOT RELATED TO SAID MOTOR VEHICLE ACCIDENT. ANY PAYMENT PURSUANT TO THIS ASSIGNMENT SHALL NOT EXCEED THE HEALTH CARE PROVIDER'S PERMISSIBLE CHARGES UNDER SAID ARTICLE 51. THIS FACILITY AND MY TREATING PROFESSIONALS CERTIFY THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE INJURED PARTY AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE INJURED PARTY FOR SERVICES PROVIDED DUE TO INJURIES SUSTAINED IN RELATION TO THE AUTOMOBILE ACCIDENT.
8. **Cost Estimates.** Estimated cost of care can be obtained by calling the Consumer Price Line (585) 758-7801. Hospital professionals and staff are not authorized to quote the cost of care or to negotiate rates.
9. **Personal Belongings.** This facility and my treating professionals are not responsible for damage or loss to personal belongings.
10. **Communications.** My treating professionals or their representative may contact me or my representative using a variety of modalities. By providing your mobile number and/or e-mail address, you consent to receive live and automated calls, text messages and/or e-mails about your healthcare. For text messages, standard message and data rates may apply. Message frequency may vary. You may opt out of text messages by replying STOP.
11. **Discharge.** I will cooperate fully with this facility's efforts to arrange a safe and timely discharge. I will provide needed financial and personal information required for discharge planning and will apply for Medicaid or other assistance needed to pay for post hospital care and to facilitate discharge.
12. **Caregiver (INPATIENTS ONLY) Designation.** I understand that I may designate a caregiver or caregivers to be included in my discharge planning. If I identify a caregiver, I understand that my caregiver will receive information and instruction about my post-discharge care.

☐ I designate _____ (Name) _____ (Relationship to me)

_____ (Address) _____ (Phone Number)

☐ I do not wish to designate a caregiver at this time.
☐ Patient is unable to designate a caregiver at this time.

****

_____ (Signature) _____ (Date) _____ (Time) _____ (Relationship to Patient (Parent, Guardian, Spouse, Self, etc))

No signature was obtained due to:
☐ Patient's condition/capacity ☐ No representative ☐ Refused to sign

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Rev. 9/22 Yellow Copy - Patient White Copy - Medical Records

PARENTS' BILL OF RIGHTS

As a parent, legal guardian or person with decision-making authority for a pediatric patient receiving care in this hospital, you have the right, consistent with the law, to the following:

1) To inform the hospital of the name of your child's primary care provider, if known, and have this information documented in your child's medical record.

2) To be assured our hospital will only admit pediatric patients to the extent consistent with our hospital's ability to provide qualified staff, space and size appropriate equipment necessary for the unique needs of pediatric patients.

3) To allow at least one parent or guardian to remain with your child at all times, to the extent possible given your child's health and safety needs.

4) That all test results completed during your child's admission or emergency room visit be reviewed by a physician, physician assistant, or nurse practitioner who is familiar with your child's presenting condition.

5) For your child not to be discharged from our hospital or emergency room until any tests that could reasonably be expected to yield critical value results are reviewed by a physician, physician assistant, and/or nurse practitioner and communicated to you or other decision makers, and your child, if appropriate. Critical value results are results that suggest a life-threatening or otherwise significant condition that requires immediate medical attention.

6) For your child not to be discharged from our hospital or emergency room until you or your child, if appropriate, receives a written discharge plan, which will also be verbally communicated to you and your child or other medical decision makers. The written discharge plan will specifically identify any critical results of laboratory or other diagnostic tests ordered during your child's stay and will identify any other tests that have not yet been concluded.

7) To be provided critical value results and the discharge plan for your child in a manner that reasonably ensures that you, your child (if appropriate), or other medical decision makers understand the health information provided in order to make appropriate health decisions.

8) For your child's primary care provider, if known, to be provided all laboratory results of this hospitalization or emergency room visit.

9) To request information about the diagnosis or possible diagnoses that were considered during this episode of care and complications that could develop as well as information about any contact that was made with your child's primary care provider.

10) To be provided, upon discharge of your child from the hospital or emergency department, with a phone number that you can call for advice in the event that complications or questions arise concerning your child's condition.

Public Health Law (PHL) 2803(i)(g) Patients' Rights 10NYCRR, Section 405.7

PATIENTS' BILL OF RIGHTS

As a patient in a hospital in New York State, you have the right, consistent with law, to:

(1) Understand and use these rights. If for any reason you do not understand or you need help, the hospital MUST provide assistance, including an interpreter.

(2) Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment, or age.

(3) Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints

(4) Receive emergency care if you need it.

(5) Be informed of the name and position of the doctor who will be in charge of your care in the hospital.

(6) Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.

(7) A non smoking environment.

(8) Receive complete information about your diagnosis, treatment and prognosis.

(9) Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.

(10) Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Deciding About Health Care — A Guide for Patients and Families."

(11) Refuse treatment and be told what effect this may have on your health.

(12) Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.

(13) Privacy while in the hospital and confidentiality of all information and records regarding your care.

(14) Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.

(15) Identify a caregiver who will be included in your discharge planning and sharing of post-discharge care information or instruction.

(16) Review your medical record without charge. Obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.

(17) Receive an itemized bill and explanation of all charges.

(18) View a list of the hospital's standard charges for items and services and the health plans the hospital participates with.

(19) You have a right to challenge an unexpected bill through the Independent Dispute Resolution process.

(20) Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital's response, you can complain to the New York State Health Department. The hospital must provide you with the State Health Department telephone number.

(21) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.

(22) Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the hospital.

Public Health Law(PHL)2803 (1)(g)Patient's Rights, 10NYCRR, 405.7,405.7(a)(1),405.7(c)

NEW YORK STATE | Department of Health