Stanford Children's Health
Johnson Center for Pregnancy and Newborn Services

Admitting Telephone Number
(650) 497-8229

Admitting Fax Number
(650) 725-3574

Lucile Packard Children's Hospital Stanford

Labor and Delivery Pre-Registration Cover Sheet

MAIL TO: Lucile Packard Children's Hospital Stanford
Attn: Admitting Department
OB Pre-Registration Forms
725 Welch Rd, Ground Floor, Suite G26
Palo Alto, CA 94304

FAX TO: (650) 725-3574

PATIENT'S INFORMATION

Patient's name: _____

Date of birth (mm/dd/yyyy): _____

Expected date of delivery (mm/dd/yyyy): _____

Date and time of online registration
(mm/dd/yyyy hh:mm am|pm): _____

Be sure to include:

- ☐ Expectant Mother's Photo ID
- ☐ Expectant Mother's Insurance card(s) (front & back)
- ☐ Expectant Mother's Prescription card
- ☐ Father/Partner's Insurance card(s) (if applicable)
- ☐ Acknowledgment of Notice of Privacy Practices form
- ☐ Permission to Call Mobile Phone form
- ☐ MyChart Proxy Access Request form
- ☐ Terms & Conditions of Service form
- ☐ Outpatient Terms & Conditions of Service form
- ☐ Advance Directive Status form
  - ☐ Advance Healthcare Directive (if you have one)

Notes:

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
LUCILE PACKARD CHILDREN'S HOSPITAL
STANFORD, CALIFORNIA 94305

ADMIN ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Stanford Hospital and Clinics and Lucile Packard Children's Hospital. Our Notice provides information about how we may use and disclose the health information that we maintain about you. We encourage you to read our full Notice.

ACKNOWLEDGEMENT OF RECEIPT: I acknowledge receipt of the *Notice of Privacy Practices* of Stanford Hospital and Clinics and Lucile Packard Children's Hospital.

Patient, Parent or Personal Representative

Signature:_____ Print Name:_____ Date:_____ Time:_____

If other than the patient, specify relationship: _____

If interpreted: _____ _____ _____
Interpreter Signature *Print Name* *Language*

_____ _____ _____
Date *Time* *Position/Relationship to Patient*

DATOS PRINCIPALES • ACUSO DE RECIBO DE LA NOTIFICACIÓN DE PRÁCTICAS DE PRIVACIDAD

Al firmar este formulario, usted confirma haber recibido la *Notificación de las Prácticas de Privacidad* de Stanford Hospital and Clinics y Lucile Packard Children's Hospital. Nuestra Notificación proporciona información sobre cómo podemos usar y divulgar la información de salud que mantenemos sobre usted. Le recomendamos leer nuestra Notificación completa.

ACUSO DE RECIBO: Confirmo haber recibido la Notificación de las Prácticas de Privacidad de Stanford Hospital and Clinics y Lucile Packard Children's Hospital.

Paciente, Padre, Madre, Representante Personal

Firma:_____ Nombre Impreso:_____ Fecha:_____ Hora:_____
Signature *Print Name* *Date* *Time*

Si no firma el paciente, indique su relación con él:_____

FOR HOSPITAL USE ONLY: INABILITY TO OBTAIN ACKNOWLEDGEMENT

If the Hospital is not able to obtain the patient's acknowledgement, record the good-faith effort made to obtain acknowledgement, and the reason acknowledgement was not obtained:

Effort to obtain acknowledgement:

❑ In-person request ❑ Request via mail (send copy of letter to HIMS for inclusion in patient's record)

❑ Request via e-mail ❑ Other:_____

Reason acknowledgement was not obtained:

❑ Patient refused to sign ❑ Patient did not return acknowledgement via mail, e-mail

❑ Patient unable to sign ❑ Other:_____

Staff: _____ _____ _____ _____
Signature *Print Name* *Date* *Time*

Stanford Children's Health | Lucile Packard Children's Hospital Stanford

Lucile Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER ● 725 Welch Road, Palo Alto, CA 94304

CONSENT-PERMISSION TO CALL MOBILE PHONE

Medical Record Number

Patient Name

Addressograph Stamp – Patient Name, Medical Record Number

Our Billing Process

Thank you for choosing Stanford Children's Health as your health care provider. We want to make sure you understand our billing process. We follow the process below to ensure that your claims are paid correctly and timely.

If you have insurance:

- We will bill your insurance first. Any deductible/co-insurance/co-pay are patient/guarantor's responsibility.
- If you have a secondary insurance, we will bill any deductible/co-insurance/co-pay deemed patient/guarantor's liability after billing your primary insurance to your secondary insurance.
- If your secondary insurance also has deductible/co-insurance/co-pay, these will be billed to the guarantor after the claim has been processed and paid by your secondary insurance.
- You will receive a copy of the Explanation of Benefits (EOB) from your insurance when they process/pay claims submitted to them. Please review and keep for your records. It will explain how the claim was processed and if and why you have any liability.

**If you have any questions about your coverage and benefits or why you have a liability on a claim, please contact your insurance for clarification. Please note that some claims takes longer to process than others. In some cases, we have to send an appeal to insurance if claims are not paid correctly.*

If you do not have insurance:

- You will be billed for the services
- If you have any questions regarding your bill, contact our customer service department at (800)308-3285, Monday – Friday from 8:00AM -5:00PM

It is important that the information we have on file is current and accurate, especially your demographic and insurance information. Please let the front desk representative know if there are any changes to your information so we can update your records accordingly.

By signing below you acknowledge you have been advised of our billing process, and if the primary contact number we have on file for you is a mobile telephone number, you agree that we, Stanford Children's Health, our agents, contractors or collection agency may call you using this mobile number using an automatic telephone dialer and/or leave you a pre-recorded and/or text messages on the mobile number. ***This consent form will remain active unless the guarantor of the account (signee) provides a written request to terminate this consent or the guarantor is changed on the account.***

If you choose not to sign below, please provide us with an alternative phone number to use to communicate billing information to you. PLEASE NOTE: If neither a signature nor an alternate number is provided, you will continue to be liable for any amounts designated as patient liability.

Print Name: _____

Signature: _____ Date: _____

Stanford Children's Health | Lucile Packard Children's Hospital Stanford

Lucile Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER
725 Welch Road Palo Alto, CA 94304

CONSENT • MYCHART PROXY ACCESS REQUEST

Medical Record Number

Patient Name

Addressograph or Label

MyChart Proxy Access Request Form- *Request for Online Access to Medical Records*

I hereby request Lucille Packard Children's Hospital Stanford/Stanford Children's Health provide access to health information in MyChart allowable by law, of the minor patient named below to the following proxy representative.

Please note the following age range limitations for MyChart. These age range limitations do not affect any legal right you have to access your child's records by other means. To request a copy of your child's record, contact the medical records department.

- If your child is age 0-11: You will be granted full access to your child's MyChart record, a subset of complete medical records
- If your child is age 12-17: You will be granted partial access to your child's MyChart record. (e.g. immunizations, messaging)
- Once your child reaches age 18, you will no longer have access to your child's MyChart record.

Please print legibly and complete all fields to ensure timely processing.

MEDICAL RECORD ACCESS REQUEST

Patient Name:	My relationship to patient:	Are you the legal custodian*?
_____ _____ First Last Date of Birth: _____ MRN: _____	❑Parent ❑Other _____	❑Yes ❑No

*Legal documents may be required, such as a birth certificate, guardianship papers, adoption documents, etc.

REQUESTOR INFORMATION (Parent/Legal Guardian)

Your Name: _____ _____
First Last

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Date of Birth: _____

Email: _____

Your Signature: _____ Date: _____

FACILITY USE ONLY

Date Received: Proxy MRN:	Patient Relationship Verified By: _____ _____ Name Phone Number **Proxy Access Approved:** ❑Yes ❑No **Letter Sent:** ❑Yes ❑No Date Sent: _____ **❑Form FAXED to HIMS for processing**

Stanford MEDICINE
Children's Health
STANFORD UNIVERSITY MEDICAL CENTER • 725 Welch Road, Palo Alto, CA 94304

Terms and Conditions Of Service

Medical Record Number:

Patient Name:

Addressograph or Label

Please read this document carefully. Lucile Packard Children's Hospital requires the Terms and Conditions of Service to be signed in its entirety, without alteration.

1. **AUTHORIZED SIGNATURE.** The patient may sign this form only if he/she is a competent adult over the age of 18 or is a minor who is permitted under state law to consent to treatment. If the patient is a minor who does not fall within the limited exceptions provided under state law or is not competent to sign this form, the form must be signed by the patient's properly designated representative or patient.

2. **MEDICAL CONSENT.** I, the undersigned, consent to the general treatment and procedures that may be performed during this hospitalization or as an outpatient (including emergency services). These procedures may include but are not limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services provided to the patient under the general and special instructions of the patient's physician or surgeon. I also authorize LPCH to use and/or dispose, at its discretion, any blood, bodily fluid, member, organ, or other tissue removed or obtained during an operation, procedure or treatment, for research that may be conducted by LPCH, Stanford Hospital and Clinics, Stanford University, or unaffiliated academic or commercial third parties if allowed under legal requirements and Stanford policies. I understand that it is the responsibility of the patient's physician to obtain the patient's informed consent when required for specific medical or surgical treatment and special diagnostic or therapeutic procedures. I understand and agree that at the request of the attending physician, allied health practitioners (such as physician assistants and nurse practitioners) may participate in the patient's care. LPCH maintains multiple patient care locations, some of which are not on the main campus of LPCH. I consent to the movement of the patient to such units, wherever situated, as are appropriate for the treatment of the patient in the judgment of my attending physician.

3. **TEACHING INSTITUTION.** Lucile Salter Packard Children's Hospital ("LPCH") is a teaching facility, training physicians, surgeons, nurses and other health care personnel. At the request, and under the supervision, of the attending physician, I agree that residents, interns, medical students, post-graduate fellows, visiting faculty members and other health care personnel in training may participate in the care of the patient. Certain medical services may be provided by individuals who do not have a physician's certificate but are qualified to participate in a special program as a visiting faculty member.

4. **PHOTOGRAPHY.** I consent to the taking of pictures, videos, or other electronic reproductions of the patient, including of their medical or surgical condition or treatment, and the use of the pictures, videos or electronic reproductions for purposes permitted by law. I consent to the evaluation and examination by a physician or other health team professionals who may be physically distant from me via virtual technologies, including but not limited to two-way video, digital images, and other virtual technologies as determined by my providers. I understand that my digital images in any form may be used for Stanford Medicine purposes, such as treatment, quality improvement, patient safety, education and security. Under specific circumstances and as required by law, I may be asked for a separate consent prior to the taking of pictures, videos or other electronic reproductions and the use or disclosure of those pictures, videos, or electronic reproductions. If the image is being used for research purposes and could be directly used to identify the patient, I will be asked for authorization to use or disclose the image as required by law.

I understand that under California law I may not photograph, film or record any image of or conversation with a SHC employee or physician or another SHC patient without the explicit consent of all parties involved and that violation of this law may result in criminal or civil liability.

5. **JOINT INFORMATION.** The undersigned understands that patient information and records may be shared between Stanford Hospital and Clinics and LPCH to facilitate patient care.

EMERGENCY PATIENTS ONLY

Agreement to paragraphs 1, 2, 3 and 4: _____

(BEFORE SCREENING EXAM) Patient or Responsible Person Signature Date/Time

6. **FINANCIALAGREEMENT.** For the services to be rendered (e.g., hospital, physician), the undersigned agrees to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of LPCH. This includes financial responsibility for all deductibles and co-payments that may be required by the patient's insurance or health plan, including Medicare and Medi-Cal. Should the patient's account(s) be referred to an attorney or a collection agency for collection, the undersigned agree to pay actual attorneys'fees and lawsuit-related expenses incurred in addition to other amounts due. When the services are to be billed to insurance, a health plan or another payment source, then paragraphs 7 (Contracted Health Plan Patients and Other Sources) and/or 8 (Assignment of Insurance Benefits) will also apply.

PLEASE SEE THE NOTICE ON RELEASE OF INFORMATION ON THE BACK OF THIS PAGE

Medical Record Number:

Patient Name:

Addressograph or Label

7. **CONTRACTED HEALTH PLAN PATIENTS AND OTHER SOURCES.** The undersigned understands that the patient may be eligible for certain health care coverage through a health plan (HMO, PPO) on the list of health plans with which LPCH contracts, or through some other source (e.g., clinical trial sponsor, employer's workers' compensation insurance). The undersigned agrees to be responsible under paragraph 6 (Financial Agreement) for paying the patient's account: (a) if LPCH does not contract with the health plan; (b) for any co-payment and deductible; (c) for services not approved by the health plan or other source; or (d) for services not covered and/or paid for by the patient's health plan or other source to the extent allowed by law or contract.

8. **ASSIGNMENT OF INSURANCE BENEFITS (INCLUDING MEDICARE BENEFITS).** The undersigned authorizes direct payment to LPCH of any insurance benefits otherwise payable to or on behalf of the patient for this hospitalization or for outpatient services at a rate not to exceed the actual institutional and professional charges. The undersigned understands and agrees that he/she is financially responsible under paragraph 6 (Financial Agreement) for charges not paid in accordance with this assignment. If applicable, the undersigned further attests that information given to LPCH to assist the patient in applying for payment under the Medicare or Medi-Cal programs is correct.

9. **DISCHARGE TIME.** Discharge time for patient is 11:00 a.m. If, due to the fault of the patient or the undersigned, discharge occurs after 11:00 a.m., the patient's account may be charged for an additional day.

10. **NURSING CARE (INPATIENTS).** LPCH provides only general duty nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. The undersigned understands that if the patient desires the services of a private or special duty nurse, the undersigned must arrange for this service. LPCH shall not be responsible for failure to provide a private or special duty nurse and will not assume any liability arising from the fact that the patient is not provided with such additional care.

11. **LEGAL RELATIONSHIP BETWEEN LPCH AND PHYSICIAN.** Lucile Salter Packard Children's Hospital at Stanford is an independent nonprofit organization that is affiliated with but separate from Stanford University. The physicians who provide care at Lucile Salter Packard Children's Hospital at Stanford's facilities are faculty, foundation, or community physicians who are not employees, representatives, or agents of Lucile Salter Packard Children's Hospital at Stanford. Lucile Salter Packard Children's Hospital at Stanford does not exercise control over the care provided by such faculty, foundation, and community physicians and is not responsible for their actions.

12. **PERSONALVALUABLES.** LPCH maintains a fireproof safe for the safekeeping of money and valuables. LPCH shall not be liable for the loss or damage to any money, jewelry, documents, or other articles of unusual value and small size, unless they are placed in the safe, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The undersigned understands that the liability of LPCH for loss of any personal property that is deposited with the hospital for safekeeping is limited by statute to five hundred dollars ($500.00) unless a written receipt for a greater amount has been obtained from the hospital by the patient.

The undersigned certifies that he/she has read <u>both</u> pages of the Terms and Conditions of Service, has received a copy of it, and is the patient or is duly authorized by or on behalf of the patient to execute and accept its terms.

_____ _____ _____ Patient or Responsible
Person Signature Date/Time Witness

Please indicate relationship of person signing this document:

Parent with Legal Custody Patient Authorized to Consent

Legal Guardian/Temporary Legal Guardian

Explain type of guardianship _____

Official documentation of guardianship (e.g., court papers) received

Person with Written Authorization (e.g., Caregiver's Authorization Affidavit, Third Party Authorization, Durable Power of Attorney)

Explain type of written authorization _____ Documentation of written authorization received

IF INTERPRETED: _____
Interpreter Signature Print Name Date/Time

_____ _____
Position/Relationship to Patient Language

PLEASE SEE THE NOTICE ON RELEASE OF INFORMATION ON THE BACK OF THIS PAGE

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE

I agree to accept full financial responsibility for services rendered to the patient and to accept the terms of the paragraphs on Financial Agreement (6), and, if applicable, Contracted Health Plan and Other Sources (7) and Assignment of Insurance Benefits (8) above.

Financially Responsible Party	Relationship to Patient	Date/Time	Witness

RELEASE OF INFORMATION

Lucile Salter Packard Children's Hospital (LPCH) may release basic information about the patient to members of the general public, but only upon receipt of an inquiry that specifically contains the patient's name, and if the patient has not requested that the information be withheld. This basic information includes the patient's general condition and location in the hospital unless the patient is being treated for certain conditions. **If you do not want such information to be released, you must make a written request that this information be withheld for each inpatient stay;** the appropriate forms can be obtained from the Admitting Service.

In compliance with the federal privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA), Lucile Salter Packard Children's Hospital provides patients with its ***Notice of Privacy Practices,*** which describes how medical information about patients may be used and disclosed, and how patients can access this information. Copies of the Notice of Privacy Practices are available at any registration desk, in the Patient & Visitors section under Patient Services of our website www.lpch.org or by calling the Lucile Salter Packard Children's Hospital's Privacy Office at 650-724-4722.

CHILD SAFETY SEATS

Regardless of age or weight, *all children* are required to be in a child safety seat, booster seat, or seat belt when being transported in a motor vehicle.

California law requires that children ***must be secured in a federally-approved car safety seat, unless they are one of the following:***

- Over 8 years of age
- 4'9 and taller
- Exceptions under the law by way of physical unfitness, medical condition, or size.

If a child is too large for a safety seat, generally around 40 pounds, a booster seat can be used.

Child safety seats including booster seats are very effective in saving children's lives. Failure to use a child passenger restraint system may increase the risk of death or serious injury to a child in an accident.

In California, traffic crashes are the leading cause of death for children ages 4 to 16 years. More than 47 percent of fatally injured children, age 4 to 7, were completely unrestrained.

Failure to properly secure a child in a child safety seat or booster seat is illegal.

A listing of low cost purchase or loan programs is available if you desire. If you would like assistance in obtaining a car seat, have further questions or would like more information about your child passenger safety, you may ask your nurse, clinic assistant or contact the Lucile Salter Packard Children's Hospital Office of Patient Relations at 650 498-4847.

Medical Record Number

Patient Name

Date of Birth

Please read this document carefully. Lucile Salter Packard Children's Hospital (LPCH) requires the Terms and Conditions of Service to be signed in its entirety, without alteration.

1. **AUTHORIZED SIGNATURE.** You may sign this form only if you are a competent adult over the age of 18 or a minor who is permitted under state law to consent to treatment. If you are a minor who does not fall within the limited exceptions provided under state law or are not competent to sign this form, the form must be signed by a properly designated representative, such as a parent or legal guardian.
2. **TERM OF AGREEMENT.** The terms and conditions in this outpatient agreement will remain in effect for one year from the date of signature. You will be asked to sign this agreement annually. At each clinic visit, you will be asked to confirm that your demographic and insurance information is correct. If your insurance or demographic information has changed, please inform the clinic staff.
3. **MEDICAL CONSENT.** I, the undersigned, consent to the general treatment and procedures that may be performed during this hospitalization or as an outpatient (including emergency services). These procedures may include but are not limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services provided to the patient under the general and special instructions of the patient's physician or surgeon. I understand that it is the responsibility of the patient's physician to obtain the patient's informed consent when required for specific medical or surgical treatment and special diagnostic or therapeutic procedures. I understand and agree that at the request of the attending physician, allied health practitioners (such as physician assistants and nurse practitioners) may participate in the patient's care.
4. **TEACHING INSTITUTION.** LPCH is a teaching facility, training physicians, surgeons, nurses and other health care personnel. At the request, and under the supervision, of the attending physician, I agree that residents, interns, medical students, post-graduate fellows, visiting faculty members and other health care personnel in training may participate in the care of the patient. Certain medical services may be provided by individuals who do not have a physician's certificate but are qualified to participate in a special program as a visiting faculty member.
5. **PHOTOGRAPHY.** I consent to the taking of pictures, videos, or other electronic reproductions of the patient, including of their medical or surgical condition or treatment, and the use of the pictures, videos or electronic reproductions for purposes permitted by law. I consent to the evaluation and examination by a physician or other health team professionals who may be physically distant from me via virtual technologies, including but not limited to two-way video, digital images, and other virtual technologies as determined by my providers. I understand that my digital images in any form may be used for Stanford Medicine purposes, such as treatment, quality improvement, patient safety, education and security. Under specific circumstances and as required by law, I may be asked for a separate consent prior to the taking of pictures, videos or other electronic reproductions and the use or disclosure of those pictures, videos, or electronic reproductions. If the image is being used for research purposes and could be directly used to identify the patient, I will be asked for authorization to use or disclose the image as required by law.

   I understand that under California law I may not photograph, film or record any image of or conversation with a SHC employee or physician or another SHC patient without the explicit consent of all parties involved and that violation of this law may result in criminal or civil liability.
6. **LEGAL RELATIONSHIP BETWEEN LPCH AND PHYSICIANS.** Lucile Salter Packard Children's Hospital at Stanford is an independent nonprofit organization that is affiliated with but separate from Stanford University. The physicians who provide care at Lucile Salter Packard Children's Hospital at Stanford's facilities are faculty, foundation, or community physicians who are not employees, representatives, or agents of Lucile Salter Packard Children's Hospital at Stanford. Lucile Salter Packard Children's Hospital at Stanford does not exercise control over the care provided by such faculty, foundation, and community physicians and is not responsible for their actions.

7. **JOINT INFORMATION.** The undersigned understands that patient information and records may be shared between Stanford Hospital and Clinics and LPCH to facilitate patient care.

8. **FINANCIAL AGREEMENT.** For the services to be rendered (e.g., hospital, physician), the undersigned agrees to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of LPCH. This includes financial responsibility for all deductibles and copayments that may be required by the patient's insurance or health plan, including Medicare and Medi-cal. Should the patient's account(s) be referred to an attorney or a collection agency for collection, the undersigned further agrees to pay actual attorneys' fees and lawsuit-related expenses incurred in addition to other amounts due. When the services are to be billed to insurance, a health plan or another payment source, then paragraphs 9 (Contracted Health Plan Patients and Other Sources) and/or 10 (Assignment of Insurance Benefits) will also apply.

9. **CONTRACTED HEALTH PLAN PATIENTS AND OTHER SOURCES.** The undersigned understands that the patient may be eligible for certain health care coverage through a health plan (HMO, PPO) on the list of health plans with which LPCH contracts, or through some other source (e.g., clinical trial sponsor, employer's workers' compensation insurance). The undersigned agrees to be responsible under paragraph 8 (Financial Agreement) for paying the patient's account: (a) if LPCH does not contract with the health plan; (b) for any copayment and deductible; (c) for services not approved by the health plan or other source; or (d) for services not covered and/or paid for by the patient's health plan or other source.

10. **ASSIGNMENT OF INSURANCE BENEFITS (INCLUDING MEDICARE BENEFITS).** The undersigned authorizes direct payment to LPCH of any insurance benefits otherwise payable to or on behalf of the patient for outpatient services at a rate not to exceed the actual institutional and professional charges. The undersigned understands and agrees that he/she is financially responsible under paragraph 8 (Financial Agreement) for charges not paid in accordance with this assignment. If applicable, the undersigned further attests that information given to LPCH to assist the patient in applying for payment under the Medicare or Medical programs is correct.

The undersigned certifies that he/she has read both pages of the Outpatient Terms and Conditions of Service, has received a copy of it, and is the patient or is duly authorized by or on behalf of the patient to execute and accept its terms.

_____ _____ _____ _____

Patient or Responsible Person Signature **DOB** **Date/Time** **Witness**

Relationship to Patient: ☐ Parent With Legal Custody ☐ Patient Authorized to Consent
☐ Legal Guardian/Temporary Legal Guardian. Explain type of guardianship: _____
☐ Official documentation of guardianship/temporary guardianship received (e.g., court papers)
☐ Person with Written Authorization (e.g., Caregiver's Authorization Affidavit, Third Party Authorization, Durable Power of Attorney). Explain type of written authorization _____
☐ Documentation of written authorization received

IF INTERPRETED: _____ _____ _____

Interpreter Signature Print Name Language

_____ _____ Position/Relationship

to Patient Date/Time

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE:

I agree to accept full financial responsibility for services rendered to the patient and to accept the terms of the paragraphs on Financial Agreement (8), and, if applicable, Contracted Health Plan and Other Sources (9) and Assignment of Insurance Benefits (10) above.

Financially Responsible Party | Relationship to Patient | Date/Time | Witness

PLEASE SEE THE NOTICES REGARDING RELEASE OF INFORMATION ON THE BACK SIDE OF THIS PAGE

PLEASE EMAIL PAGE 1 AND PAGE 2 TO HIMS-LPCH@STANFORDCHILDRENS.ORG

RELEASE OF INFORMATION

In compliance with the federal privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA), Lucile Salter Packard Children's Hospital provides patients with its ***Notice of Privacy Practices,*** which describes how medical information about patients may be used and disclosed, and how patients can access this information. Copies of the Notice of Privacy Practices are available at any registration desk, in the Patient & Visitors section under Patient Services of our website www.stanfordchildrens.org or by calling the Lucile Salter Packard Children's Hospital's Privacy Office at 650-724-4722.

FINANCIAL ASSISTANCE AVAILABLE

Lucile Packard Children's Hospital has a variety of financial assistance options available to patients who are uninsured or underinsured. Lucile Packard Children's Hospital will assist patients in determining if they qualify for financial assistance or if there are programs available that may help pay for medical services. Additional information and/or a statement of charges for services provided by Lucile Packard Children's Hospital can be obtained by contacting the Customer Service Unit of Patient Financial Services at 800-549-3720.

Financial assistance applications are available at all Packard clinics and hospital registration areas. The application can also be found on our website at www.stanfordchildrens.org in the Patients and Visitors section under Financial and Insurance Information or by calling the customer service number above. Applications are reviewed to determine what assistance may be available; applicants are notified of the outcome of this review within 10 business days after the completed and signed application is received.

Patients who qualify may receive assistance with bills for services provided by Lucile Packard Children's Hospital and by physicians employed by Stanford University. Services may include inpatient and outpatient care, emergency services, co-payments and deductibles, non-covered charges, denied days and stays, and other special circumstances. Patients who have no insurance or inadequate insurance and meet certain low- and moderate- income requirements may qualify for discounted payment or charity care.

NOTICE ABOUT OPEN PAYMENTS DATABASE

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

Lucile Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER
725 Welch Road Palo Alto, CA 94304

Medical Record Number

Patient Name

Addressograph Stamp - Patient Name, Medical Record Number

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

ADVANCE DIRECTIVE INFORMATION FORM

I. Advance Directive Status at time of Admission

- ❑ **Patient is unable to answer questions about his/her Advance Directive.** (Contact Patient Relations at 8-4847 or Social Services 7-8303)
- ❑ I do not have an Advance Directive, and I am not interested in receiving further information
- ❑ I do not have an Advance Directive, but would like further information
  - ❑ I have received the brochure entitled "Your Right to Make Decisions about Your Medical Treatment"
- ❑ I do not have an Advance Directive, but would like to complete one. (Contact Patient Relations at 8-4847 or Social Services 7-8303)
  - ❑ I have received the Advance Health Care Directive kit
  - ❑ Advance directive completed

_____ _____
Patient Relations/Social Services Signature Date

- ❑ I have an Advance Directive and have provided a copy.
  (One copy each to the patient's medical record and admitting; patient keeps original)
- ❑ I provided a copy of my Advance Directive at the time of a previous admission.
  (Staff contacts Admitting (7-8229) to check in Admitting AD file. If AD is available, Admitting will fax it to the unit, then ask the patient to review it)
  - ❑ I verify that the information in the Advance Directive dated _____ is still correct.
- ❑ I have an Advance Directive, but do not have a copy with me. I understand that in the interim, until my health care directive is available to LPCH staff, I am responsible for discussing my health care wishes, including identification of a surrogate decision-maker, with my physician.

Patient (or representative) signature: _____

If representative, relationship to patient: _____

Social Services/Patient Admitting Service Staff _____
Title

Date: _____ Time: _____

NOTE: If you have any questions regarding this document, please contact Patient Relations at 8-4847 or Social Services at 7-8303.