Consent for Treatment

Please read this form. Ask questions about anything you do not understand before you sign.

Treatment

• I authorize doctors, other providers and Children's Hospital of Wisconsin (CHW) employees to evaluate and treat my child. This may include, but is not limited to, all routine hospital services, physical examinations, x-rays, labs, administering or prescribing medications including immunizations and ordering or performing other tests or procedures. I have the right to discuss options for my child's treatment. I will be given a chance to ask questions as needed.

• A hospitalist or a specialty doctor may be assigned to treat my child. CHW staff will carry out the instructions of these doctors. I understand that most doctors who care for my child are not employees of CHW. CHW is not responsible for their actions.

• My child may go home or to another facility before all medical problems are known or treated. I agree to make appointments for follow-up care.

• CHW is a teaching hospital and supports the training and teaching of health care professionals. Students may be involved in providing my child's care.

• CHW may use or properly dispose of any samples or tissues taken from my child's body.

Patient Rights and Privacy

• Patient/Family Rights and Responsibilities information is posted throughout CHW. I may request a copy. It is also available at CHW.org.

• I received the Notice of Privacy Practices. It explains how my child's health information may be handled and is posted throughout CHW and is available at CHW.org.

• Photographs and recordings may be taken by CHW for care, training, education or security purposes. I am not allowed to take photos or videos of other patients or of staff when they are providing care to my child.

• My child's medical records may be shared with health providers, insurance companies and Children's Hospital and Health System for treatment, payment and health care operations.

• CHW is not responsible for my valuables. I understand that I should take anything valuable home.

Financial Agreement

• I will receive more than one bill for my child's inpatient or outpatient appointment. All insurance payments for my child's care are paid to CHW and to providers who may care for my child. I understand that I am responsible for charges not covered by insurance.

Communication

• You may need to call, email or text me about appointments, treatment, billing and collections. Prerecorded messages and auto-dialers may be used when contacting me. I give you permission to contact me at any of the telephone numbers/email addresses provided and know that may result in charges to me.

I have read this information. I am legally able to consent for my child. By signing this form, I give my permission for treatment and agree to the terms listed above. My consent for clinic visits is good for one year.

Signature: X ____________________________ Relationship to Patient: ____________________________
Patient, Parent or Legal Guardian

Date: ___________ Time: ___________

Verbal Consent: ☐ Yes ____________________________ Relationship to Patient

CHHS Witness to the Signature

Second CHHS Witness to Verbal Consent

☐ Parent/Legal Guardian ID verified (Inpatient/Day Surgery only) by: ____________________________ Date: ___________ Time: ___________