THE RONALD MCDONALD CARE MOBILE

As a collaboration between UPMC Children's Hospital of Pittsburgh, and Ronald McDonald House Charities of Pittsburgh and Morgantown, Inc., the Care Mobile offers no out-of-pocket cost medical care to children throughout Pittsburgh and the surrounding areas.

To schedule an appointment with the Care Mobile, call or text: 412-352-1060

Have any questions or need more information?
Call 412-352-1059 or visit us at www.chp.edu/our-services/mobile-medical-unit

SERVICES PROVIDED:

- Well-child visits and infant care
- Sick child visits
- Immunizations
- Routine physical exams
- Adolescent and young adult health care
- Referrals for specialty care
- WIC (Women, Infants & Children) form assistance

ALL SERVICES PROVIDED BY THE CARE MOBILE ARE AT NO OUT-OF-POCKET COST

SERVICES ARE COMING YOUR WAY! LOOK FOR THE CARE MOBILE ON:

LOCATION: Ambridge Area High School - 901 Duss Ave, Ambridge, PA 15003

DATE: June 24th, 2021 **TIME:** 10AM - 2PM

UPMC | CHILDREN'S HOSPITAL OF PITTSBURGH

Ronald McDonald House Charities

UPMC | CHILDREN'S HOSPITAL OF PITTSBURGH

Patient Name

Medical Record Number

Birthdate

CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO)

UPMC for the purposes of this Consent, includes all hospitals, physician offices and other facilities providing healthcare services which are part of the UPMC system.

I. CONSENT TO TREATMENT

This consent cannot be modified.
Any handwritten changes to the form shall not be legally binding or enforceable.

1. I, _____ **(print or type name)** on behalf of _____ (patient name and relationship) consent to the provision of treatment that may include diagnostic procedures, medical treatment by and/or admission to UPMC, including its hospitals, other health care facilities and physicians (all "affiliates"), which my physician or his/her authorized agent may consider necessary or advisable. I understand special consent forms may need to be signed for specific procedures. If I have a religious objection to specific care to be provided I may ask UPMC not to provide such care.
2. I understand that my care may include examinations, diagnostic tests, medical treatment, taking photographs/video and making audio recordings that may be used for my care and/or by UPMC for education.
3. I understand and agree that others, under the direction of a physician, may assist or participate in providing hospital and/or medical care to me at UPMC teaching facilities. These people may include but are not limited to residents, fellows, and medical/nursing students.
4. I give UPMC and its designees permission to use my information as described in the *UPMC Notice of Privacy Practices*.
5. If applicable, I give UPMC permission to appropriately dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my body. Once disposed of, specimens/tissue cannot be retrieved. I understand and agree that UPMC and its designees may use such specimens/tissue as part of its educational activities. I understand that state and federal law allows UPMC to use specimens/tissue for research purposes without my authorization if my identity is not linked to the specimens/tissue. I will be asked to provide authorization for use of my specimens/tissue in research if my identity is linked to the specimens/tissue.
6. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.

II. MEDICARE CERTIFICATION (IF APPLICABLE)

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization providing the services or authorize that physician or entity to submit a claim to Medicare for payment to me.

III. MEDICAID CERTIFICATION (IF APPLICABLE)

I certify that the information given on this consent is true, complete, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds and that any false claims, statement, documents, or concealment of material facts, may be prosecuted under applicable federal and state laws. My signature at the end of this consent acknowledges my receipt of an important message from MEDICARE/MEDICARE HMO/TRICARE (formerly known as CHAMPUS / CHAMPVA) and does not waive any of my rights to request a review.

IV. RECEIPT OF NOTICE OF PRIVACY PRACTICES/RELEASE OF INFORMATION

1. I have been provided the *UPMC Notice of Privacy Practices*, which may have been provided to me during a previous visit.
   _____ **Patient Initials (required)**
2. I consent to access by any UPMC affiliate (including UPMC hospitals, staff, physicians providing services to me and other entities and programs) to my medical or other information maintained on electronic information systems or stored in various forms at individual UPMC affiliates related to my treatment and/or services. I also consent to UPMC providing such information to my primary care/family physician(s) and others as necessary for referral, consultation, treatment and/or the provision of other treatment-related healthcare services to me. However, my specific consent to release behavioral health information will be obtained as required by law.
3. I understand that my information may be released if required by local, state or federal law.

UPMC | CHILDREN'S HOSPITAL OF PITTSBURGH

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V. FINANCIAL ARRANGEMENTS

I agree to the following terms related to payment for services provided by UPMC and affiliates.

1. I authorize UPMC to bill my insurance carrier and request such payments to be made directly to UPMC. I certify that the information I have given about my insurance coverage or other payment sources is correct.
2. I assign to UPMC all rights to insurance payments or benefits to which I may be entitled for services provided to me by UPMC. I authorize UPMC to act on my behalf and as my representative to request reconsideration (internal and/or external review process) by my managed care plan or utilization review entity for coverage or grievance review.
3. I authorize UPMC to release any medical or other information about UPMC services, or services provided by third parties, if required to obtain payment from my insurer or other payor and their agents to process payments. I also authorize UPMC to release any medical or other information required by my insurer, other payors and their agents. I also authorize UPMC to release medical or other information required by my insurer, other payors and their agents, government agencies or their designees for review of the care provided to me.
4. I assign all rights to benefits, insurance proceeds or other payments or judgments to which I may be entitled for hospital based physician services (pathology, radiology, neurology, cardiology, anesthesiology, etc.) and/or emergency room services to the physician or organization providing the service. I also authorize submission of a claim for payment on my behalf to my insurance carrier.
5. I understand that any amounts not paid by my insurance are my responsibility.
6. If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payor regarding those services, I understand that a separate financial agreement will be put into place regarding the self pay services and this section will not apply to such services.

VI. PATIENT VALUABLES

I relieve UPMC of any responsibility for loss of clothing, money, valuables, dentures, glasses, or any other items that I decide to keep with me while I am a patient. I further understand that UPMC will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me, or any property brought to me while I am a patient.

VII. AGREEMENT TO MEDIATE CLAIMS

I agree that any claim which may result from the care provided to me by the doctors, nurses and other health care providers in any UPMC facility shall be subject to the laws of Pennsylvania. I also agree that before any lawsuit is filed related to the care provided to me, I must attempt to resolve any claim through mediation, which must take place in the Commonwealth of Pennsylvania. I am not waiving my right to a jury trial. Mediation is a process in which a neutral third person tries to help settle a claim. This agreement is binding on me and any person making a claim on my behalf.

MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s) _____

_____, I am entitled under Pennsylvania Law to consent to medical, dental or other health services for myself, and if applicable, for my minor children without the consent of any other person.

_____ **Patient Initials (required if completing this section)**

I have read this Consent for Treatment, Payment and Health Care Operations form or have had it read to me, and it has been explained to my satisfaction. I understand that this Consent for Treatment, Payment and Health Care Operations form is valid for one (1) year from the date that I sign it and applies to all UPMC facilities (such as physician practices, hospitals, clinics, etc.) except for behavioral health facilities, where a separate consent may be required for an encounter.

Patient Signature	Date	Time	Signature of UPMC Representative
Signature/Identity on behalf of patient/relationship Name	Date	Time	Signature of UPMC Representative

FOR OFFICE USE ONLY

Patient Name: _____ Account Number: _____ MRN: _____

☐ Sign here if patient failed to acknowledge receipt of Notice of Privacy Practices: _____

Reason given for refusal: ☐ Previously received ☐ Patient did not specify ☐ Other: _____

Children's Hospital of Pittsburgh | of UPMC

HEALTH PARTNERSHIP CONSENT
CHILDREN'S HOSPITAL OF PITTSBURGH OF UPMC
RONALD McDONALD CARE MOBILE
412-692-7777
Parent Consent for Health Services

Form CHP0400 12/08

Patient Name

Medical Record Number

Birthdate

CONSENT / MEDICAL INFORMATION

I give consent for my daughter/son, _____

born on _____ to receive the services at the Care Mobile.

Patient's Primary Care Physician _____

These services are provided by Children's Hospital of Pittsburgh of UPMC.
Please check any of these services that you **do not** wish to be provided for your child.

- ☐ Physician Exams–Routine drivers licensure, work, camp, college, sports, school
- ☐ Diagnosis of and treatment of illness and injuries
- ☐ Management of chronic illnesses
- ☐ Immunizations
- ☐ Preventative screening and health education services

(Specifically for Pulmonology Pediatric Patients Only)

- ☐ Physical Exams
- ☐ Screening and Diagnosis of asthma and other associated conditions
- ☐ Pulmonary Function Testing both before and after administration of albuterol to determine the severity of asthma
- ☐ Referrals to specialty care for other chronic illness
- ☐ Preventive Screening and health education services
- ☐ Asthma education

Please list any allergic reactions to medicine _____

Current medications _____

Medical History including prematurity _____

Hospitalization due to breathing problems/pneumonia _____

Emergency room visits due to breathing problems _____

PERMISSION / RELEASE

I understand that the confidentiality of the patient's medical record is required by law, and the record will not be released to any person or entity without prior written permission, except as otherwise authorized by law.

This Ronald McDonald Care Mobile is made possible by a grant from the Ronald McDonald House Charities, Inc., a non-profit, tax-exempt charitable corporation. RMHC has no responsibility or liability for the operation of this Ronald McDonald Care Mobile or any of the medical or dental activities conducted herein.

AUTHORIZED SIGNATURES

Name of Parent/Legal Guardian Signing Authorization *(Print)* _____ Home Phone # _____ Business Phone # _____

Parent/Guardian Birth Date _____

Other Parent/Legal Guardian If Applicable _____ Home Phone # _____ Business Phone # _____

Address of Student *(#, Street, Zip Code)* _____

Signature of Parent/Legal Guardian _____ Date _____

0400

Children's Hospital of Pittsburgh | of UPMC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

CHP-3005 12/14

I hereby authorize **Children's Hospital of Pittsburgh of UPMC (CHP)** to release information from the record of

_____ ; _____ as described below to
Patient Name Birth Date

Name of Facility/Person: _____

Address: _____

Phone: _____ Fax: _____

Records are requested for the purpose of: ☐ Continuing care/Medical Facility ☐ Legal ☐ Personal Use
☐ Insurance ☐ Other: _____

Documentation can be released electronically if stored in an electronic media. ☐ ***Please check for release on CD***

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Type of records to be released and date(s) of service (*check all that apply*)

☐ Inpatient - Dates: _____ ☐ Outpatient Testing - Dates: _____

☐ Same Day Surgery - Dates: _____ ☐ Physician Office/Clinic - Dates: _____

☐ Emergency Dept. - Dates: _____

2. Information to be released:

☐ Problem List	☐ Pathology Report	☐ Laboratory Tests/Results
☐ Medication Lists	☐ Nurses Notes	☐ Radiology Report
☐ Allergies	☐ Physician Orders	☐ Radiology Images
☐ Procedure List	☐ Physician Progress Notes	☐ EKG Report(s)
☐ Emergency Department Report	☐ Discharge Instructions	☐ Diagnostic Tests *(cardiology studies, ECHO, EEG, EMG, pulmonary function, audiology)*
☐ History & Physical Exam	☐ Discharge Summary	
☐ Consultation Report	☐ Psychiatric Evaluation	
☐ Operative Report	☐ Rehabilitation Records	☐ Other: _____

HIV, Mental Health and Drug & Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release: ☐ HIV ☐ Mental Health (Psychiatric) ☐ Drug & Alcohol

I understand the following:

- That this Authorization is in effect for a period of 90 days from the date of signature, unless a specific time frame is documented; however, no time frame specified shall go beyond one year from the date of signature.
- That I have the right to revoke this Authorization form at any time by sending a written request to Children's Hospital of Pittsburgh of UPMC, Health Information Management Services at the following address: 4401 Penn Avenue, Pittsburgh, PA 15224.

See side two of this form for additional patient rights and responsibilities.

_____ _____ _____ _____
Date of Signature | Signature of Authorized Representative | Date of Signature | Signature of Patient (14 years of age or older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.)

☐ Parent or Legal Guardian ☐ Power of Attorney
☐ Next of Kin of Deceased ☐ Executor of Estate

_____ _____
Print Name of Authorized Representative | Print Name of Patient

_____ _____
Authorized Representative Email | Patient Email

ORAL AUTHORIZATION (for persons unable to sign)
NOT Applicable to HIV related information or Drug & Alcohol Treatment Information
I witness that the patient/parent/legal guardian understood the nature of this release and freely gave their oral authorization (Two witnesses are required)

_____ _____ _____ _____
Date | Witness #1 | Date | Witness #2

Please be aware that heath care facilities are authorized by Pennsylvania State & Government Regulations to charge for the reproduction of medical records and that charges may be associated with this request.

ADDITIONAL PATIENT RIGHTS AND RESPONSIBILITIES

I understand the following:

- A disclosure statement, as required by law, will accompany all records released.
- That my/my child's health record(s) will not be released or obtained by CHP unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information.
- That the release of my/my child's health record(s) will be for the purpose stated on this form, and only those items checked off will be released.
- That the health record(s) released by CHP may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) CHP and its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- That my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.
- That my decision to revoke the Authorization may result in my insurance company not being able to pay for my/my child's medical care and I may be liable for payment of the claim.
- That CHP will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization or not.
- That I am entitled to a copy of this completed Authorization form.
- In accordance with Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or government officials shall be restricted to the following: 1) Whether the client is or is not in treatment 2) The prognosis of the client 3) The nature of the program 4) A brief description of the progress of the client 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.