Atrium Health
Levine Children's

ENROLLMENT AND CONSENT FORM

PATIENT INFORMATION

Name:_____ Date of Birth: _____
(mm/dd/yyyy)

Address:_____ City/State/Zip: _____

Name of Location:_____

PARENT/GUARDIAN INFORMATION

Parent/Guardian:_____ Date of Birth: _____
(mm/dd/yyyy)

Address:_____ City/State/Zip:_____

Relationship to Patient :_____ Phone: (H)_____ (W)_____ (C)_____

Alternate Contact: _____ Phone: (H)_____ (W)_____ (C)_____

Alternate Contact: _____ Phone: (H)_____ (W)_____ (C)_____

RELEASE OF INFORMATION

In treating your child with Atrium Health Community-Based Virtual Care (Virtual Care), his/her information will be used and shared to provide care or conduct healthcare operations. For example, we may use your child's information to coordinate care with other providers; we may share information with personnel about how to administer medications or accommodate your child's condition; we may use the information to evaluate how the services were delivered and health situation. We may also receive information from other providers and pharmacies, such your child's health history and medication list. We will keep a copy of this information in your child's record. In addition, we may release your child's medical information, including information regarding communicable diseases (including COVID-19), and any clinical, lab and radiology reports, to the community organization representatives and the local health department for safety reasons, as as necessary to provide medical care and treatment to your child and to coordinate care. By signing below you give permission for Virtual Care to share information as described above.

For more information about how your child's information may be used or disclosed, please review our Atrium Health Notice of Privacy Practices available on our website AtriumHealth.org under the Privacy Practices link at the bottom of the page for more information. A paper copy can be accessed at the facility where services are delivered. I acknowledge that a copy of the Atrium Health Notice of Privacy Practices has been made available to me.

Parent/
Guardian:_____ Date:_____

PRIVACY

All persons have health issues that must be handled in a confidential manner. Staff will share confidential information only when necessary to address potential health care needs, to ensure the safety of the patient, other children, and staff, or other situations specified by law. I give permission for designated personnel to share information with Atrium Health Community-Based Virtual Care clinics and its providers, about my child's health history if appropriate, and/or other emerging health concerns, included but not limited to information related to communicable diseases (including COVID-19), evaluation for ADD/ADHD, development concerns such as speech delays, medications, results of physical examinations, consults and diagnostic results or other clinical, behavioral (including school-based teletherapy), developmental or related reports and records, and any other information for the coordination of care.

Parent/Guardian Initial_____

VIRTUAL CARE

By signing below, you are acknowledging that you understand the risks and benefits of your child receiving treatment through Virtual Care and you give consent for us to treat your child by Virtual Care. Virtual care is the use of electronic information and communication technologies by a healthcare provider (using interactive audio, video or data communications) to deliver services to your child when the provider is located at a different place. Not every condition can be treated by virtual care. If your child's treatment provider believes your child would be better serviced by in-person treatment you will be notified and referred to an in-person setting for further care. Your child's care team will decide if more treatment is needed at the hospital.

Virtual care encounters are still subject to the requirements of the HIPAA Privacy Rule that apply to Protected Health Information (outlined in the Release of Information section above). If you text or email us with patient information in an unsecured manner, you understand the risks of doing so (see our Guidelines for Email under the above Privacy Practices link for examples) and give us permission to respond to you in a similar, unsecured manner. There is the risk that treatment provided by Virtual Care could be disrupted due to technical failures.

INSURANCE

Many insurance plans are covering virtual care services at this time. You authorize Atrium Health to contact your insurance carrier to determine eligibility for payment and to bill your health insurer for covered services. You understand that you may be responsible for copays and deductibles related to these services.

Please fill in the information below:

Insurance Carrier:_____Subscriber ID/Policy Number:_____

Group Number:_____Member Relationship to Subscriber: _____

By initialing your name below, you acknowledge the above and give permission for Atrium Health Community-Based Virtual Care to bill your insurer for covered virtual care services.

Parent/Guardian Initial_____

CONSENT FOR SERVICES

Please be aware that this Enrollment and Consent form ("Consent") applies to all virtual care services provided by Atrium Health Community-Based Virtual Care ("Virtual Care") regardless of location within the community. Unless Virtual Care is otherwise notified by you, this Consent applies to services provided at: schools, daycare centers, camps, summer programs, the local YMCA, the Boys & Girls Club, and other venues and locations in the community where Virtual Care is offered. You will always be contacted at the time of service to confirm your consent to a particular encounter.

Any request for revocation of Consent for Services, or to opt out of Enrollment and Consent for Virtual Care at a particular location, must be in writing and sent to Attn: Atrum Health Community-Based Virtual Care at the facility address where services are delivered.

By providing my initials below, I agree as legal custodian of my child that I have read, accepted, and agreed to be bound by this consent, notice and acknowledgment in relation to the services, including virtual care services, provided to my child. I understand that if I do not sign this document, my child will not be able to receive treatment as a part of the program.

Parent/Guardian Initial _____