Children's Hospital
of The King's Daughters
Sports Medicine
*Training and Treatment for Young Athletes*
(757)668-PLAY
www.chkd.org/sportsmed

June 15, 2023

Dear Parents,

As part of our commitment to serve the sports community, Children's Hospital of the King's Daughters (CHKD) Sports Medicine Program has joined with Governor's School for the Arts (GSA) to provide on-site medical screenings. Dr. Joel Brenner, a sports medicine physician with expertise in assessment and treatment of dancers and other performing artists, and Emily Hafer, a sports medicine physical therapist (PT), will come to the dance studio most Wednesdays to assess any musculoskeletal injuries or painful conditions that the students are reporting. After screening from either Dr. Brenner or Emily, a recommendation may be made for either a follow-up physician visit (you can choose to follow up with either Dr. Brenner by calling 668-PLAY (7529) or with your child's own physician) or your child may be given some physical therapy exercises to do on their own in an attempt to mitigate further programs. CHKD provides this service in the studio free of charge. Often when minor injuries and pains can be assessed early, interventions can be given to decrease pain and prevent further injury.

You may choose whether or not to allow your child to be screened by our medical team. If you agree, please complete the attached forms and return to GSA Department. The forms are as follows:

1. Treatment and Payment acknowledgment: This MUST be signed to allow your child to participate in the screening. Please initial each box and sign at the bottom **(no payment will be collected at any time)**
2. Email consent form: Allows the staff at CHKD to reach out to you regarding any concerns
3. Authorization to disclose information: Allows the staff at CHKD to share the results of any screens with the staff at GSA
4. Sports Performance Academy Waiver: Provides CHKD staff with emergency contacts, as well as any pertinent history

If you have any questions about this program, feel free to contact Emily Hafer, PT, DPT, SCS, CHKD's Dance Program Coordinator at 757-668-2394.

Thank you,

CHKD's Sports Medicine Team

0 0 7 5 9

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

**Children's Hospital of The King's Daughters Health System**

**TREATMENT AND PAYMENTACKNOWLEDGMENT/CONSENT**

## CONSENT FOR TREATMENT

I hereby request and consent to medical and/or diagnostic treatment, including admission if deemed necessary, by Children's Hospital of The King's Daughters, Incorporated ("CHKD"), Children's Medical Group, Inc. ("CMG"), Children's Surgical Specialty Group, Inc. ("CSSG") (CHKD, CMG, and CSSG are collectively referred to herein as "Children's Hospital of The King's Daughters Health System" or "CHKDHS") and/or Children's Specialty Group, PLLC ("CSG"), and hereby authorize such entities and their physicians (and whomever he/she may designate as his/her assistant(s), including Residents and any CHKD professional staff physician) and employees to treat myself or minor(s) in my legal custody, including stepchildren, in ways they determine to be therapeutically necessary. I understand that this treatment may include tests (lab/diagnostics), examinations, administration of medications, and medical or surgical procedures. I understand that during treatment, the possibility exists for health care workers to become directly exposed to the individual's blood or body fluids. Virginia law authorizes health care providers to test patients for HIV and Hepatitis B & C antibodies when a health care provider or any person employed by or under the direction and control of a health care provider is exposed to the body fluids of a patient in a manner that may transmit HIV or the Hepatitis A or B viruses. In the event of exposure, I understand that I will be deemed to have consented to testing, and consent to release test results to the health care worker who may have been exposed. Prior to testing, I will be informed and given an opportunity to ask questions. I consent to the release of prescription history from any drug pharmacy or drug monitoring agency to my physician or healthcare provider. I further consent to the taking of photographs/videos for treatment, security, public health, healthcare operations, and/or payment purposes. Date: _____ Initials: _____

## OBLIGATION OF PAYMENT

I irrevocably direct and assign payment from my insurance company, Medicaid, Medicare, Tricare, or other provider of health care benefits to CHKDHS and/or CSG for services rendered. **I understand that my insurance policy is a contract between my insurance company and me, and that I am responsible to CHKDHS and/or CSG for any charges not covered by my insurance, including co-payments, deductibles, and fees for non-covered services. Since most physicians are not employed by the hospital, the hospital and physician will bill separately for services rendered. Some insurance plans require the laboratory and/or radiology department performing tests to bill for such diagnostic tests. In these instances, I understand that I will receive a separate statement and bill from the laboratory and/or radiology department performing the test.** If all charges are not paid when due to CHKDHS and/or CSG, the undersigned agrees to pay all costs of collection, including collection agency and attorney's fees in an amount not to exceed thirty three & one-third % (33 1/3%) of the balance placed with agency and attorney, which shall be deemed incurred upon referral.

Date: _____ Initials: _____

## BALANCES DUE AND BILLING QUESTIONS

Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement. Co-payments and other self-pay amounts are due prior to leaving the hospital and/or practice. I have been informed that a fee of $25.00 may be applied to my account for any returned checks. The RETURNED CHECK FEE is only payable in cash or by money order. All billing inquiries can be directed to the CHKDHS and/or CSG Billing Representative where care was received. Date: _____ Initials: _____

## COMMUNICATION PREFERENCE

- If email address(es) is/are provided, I consent to CHKDHS' and/or CSG's use of encrypted email to send me communications that may include protected health information.
- If mobile phone numbers is/are provided, I consent to CHKDHS and/or CSG's use of unsecured SMS text messaging to send me communications that may include protected health information.

**By signing this consent form, I acknowledge that I have the authority to provide consent and am granting permission to CHKDHS and/or CSG or their affiliates, clinical providers, business associates, billing services, collection agencies, agents, or third parties who may act on their behalf to contact me for any reason or purpose, including those related to my account, insurance, billing, payment, and/or the care rendered on the mobile phone number(s) provided on this or other form(s) or updated at a later time. I understand that I may choose to grant permission to contact me via phone call and text message, or phone call only (no texts). Consent is not required; I may opt-out of communications sent to my cell phone number(s). I retain the right to revoke permission at any time. I understand that communications may be made as a direct dial call or through the use of SMS text messages, live, pre-recorded or artificial voice messages, and/or the use of an "automated telephone dialing system," computer-aided technologies, or "autodialer". Depending on my mobile service plan, message and data rates may be assessed by my mobile provider. I may withdraw consent or opt-out at any time by providing written notice to Physician Practice Management, by emailing Text.Opt@chkd.org, by calling CHKD at (757) 668-8577, or by visiting the website www.chkd.org/TextOpt . Responding to SMS text messages with "STOP" will also withdraw my consent. I understand that the person signing is not required to sign the agreement as a condition of securing or receiving any services with CHKDHS and/or CSG.**

**Date: _____ Initials: _____**

## ACKNOWLEDGMENTS/CERTIFICATIONS

I, the Parent/Legal Guardian/Patient, acknowledge and certify the following:

- I received a medical screening and stabilization treatment prior to being asked about financial information while seeking care for a deemed medical emergency.
- I was offered (a) the "Patient/Family Rights & Responsibilities" form and provided (b) the Organized Healthcare Arrangement "Notice of Privacy Practices" form on the date of this Agreement and was given an opportunity to ask questions about the information provided.
- I have read and agree to the terms of the "Patient Financial Policy". I certify that I understand the payment terms contained in this form.

I certify that this form has been fully explained to me, that I have had any necessary communication assistance, I understand the contents of this form and that I am the patient or the patient's parent/legal guardian and have the authority to request this treatment. Furthermore, I permit a copy of this document to be used in place of the original. I certify that all statements are true and correct and I understand that false statements or documents or concealment of a material fact may be prosecuted under federal or state laws. I acknowledge that any form completed by CHKDHS and/or CSG shall not be changed or altered by a parent/guardian/patient and understand that if it is changed or altered, it may jeopardize my child's health or safety based on provider(s)'s recommendation(s).

Date: _____ Initials: _____

**Advance Directive** to be completed if patient is an adult (18 years or older): Does the patient have an advance directive? ____Yes ____No

| **PATIENT(S) NAME (please print):** | **DATE OF BIRTH:** |
|---|---|

| SIGNATURE OF PATIENT/LEGAL GUARDIAN | RELATIONSHIP TO PATIENT/LEGAL AUTHORITY | DATE | TIME |
|---|---|---|---|
| | | | |

Witness: _____ Date: _____ Time: _____

For office use only:

| 2nd Witness: (Verbal Consent Only) | Date | Name of Person Accompanying Patient |
|---|---|---|
| | | |

0 0 8 4 8

**Children's Hospital of The King's Daughters, Inc.**
601 Children's Lane, Norfolk, VA 23507-1910

# PATIENT/HEALTH CARE PROVIDER E-MAIL/TEXTING CONSENT



Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

## 1. RISKS OF USING E-MAIL AND TEXT MESSAGING

CHKDHS and CSG offer patients/parents/legal guardians the opportunity to communicate by e-mail or text messaging. Using e-mail to discuss patient information, however, is different than phone messaging. Text messaging is not to be used to convey medical information or to discuss medical conditions. E-mail and/or text message communication has a number of possible risks that patients/parents/legal guardians should consider before using e-mail or text messaging. If the patient/parent/legal guardian is worried about any information being seen by other people, or if the question or problem is urgent, then other form(s) of communication such as telephone communication should be used. Some of the possible risks of using e-mail or text messaging include, but are not limited to, the following:

a. E-mail information or text messages can be sent on to other people, stored on a computer, or printed out on paper for storage.
b. E-mail or text messages can be sent out and received by many recipients, some or all of whom may be sent the e-mail accidently.
c. E-mail or text message senders can easily misaddress their message.
d. E-mail or text message information is easier to change than handwritten or signed documents.
e. E-mail or text message information may be kept on computers/electronic devices even after the sender or the recipient believes they deleted his or her copy.
f. Employers and on-line services have a right to archive (store) and look at e-mails/text messages transmitted through their systems. Some, but not all, employers store e-mail/text messages indefinitely.
g. E-mail/text messages can occasionally be intercepted, changed, forwarded, or used without authorization or detection.
h. E-mail or text messages can be used to introduce viruses into computer systems.
i. E-mail or text messages can be used as evidence in court.

## 2. CONDITIONS FOR THE USE OF E-MAIL AND TEXT MESSAGING

The health care providers will use reasonable means to protect the security and confidentiality of e-mail/text message information sent and received. However, because of the risks outlined above, the health care providers cannot guarantee the security and confidentiality (privacy) of e-mail/text messaging communication, and **will not be liable** for improper use and/or disclosure of confidential information (including Protected Health Information (PHI) that is the subject of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)). Thus, the patient/parent/legal guardian must consent to the use of e-mail for patient information. Consent to the use of e-mail/text messaging includes agreement with the following Conditions:

a. E-mails to or from the patient/parent legal guardian concerning diagnosis or treatment will be printed out and/or made part of the patient's medical record. Because they are then a part of the medical record, other individuals who are authorized to view the medical record, such as staff and billing workforce members, will also have access to those e-mails.
b. The health care providers may forward e-mails/text messages internally to other staff or agents of the health care providers/their practice as necessary for diagnosis, treatment, reimbursement, and other operations. The health care providers will not, however, forward e-mail or text messages to independent third parties outside of CHKDHS or CSG who are not involved with the patient's treatment, reimbursement, or otherwise involved in their care, without the patient/parent/legal guardian's prior written consent, except as authorized or required by law. The health care providers may possibly forward e-mail/text messages to other health care providers participating in the patient's care.
c. Although the health care providers will try to read and respond quickly to an e-mail or text message from the patient/parent/legal guardian, the health care providers cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. The usual period of time is less than one (1) business day, but it may take up to a week or longer if the person to whom the e-mail is sent is away or if the e-mail system is not working. Thus, the patient/parent/legal guardian **should not use e-mail for medical emergencies or other matters that have to be handled quickly**.
d. Text messages are used by health care providers for appointment reminders or to share more generic information. When text messages are sent by a patient/parent/legal guardian there should not be an expectation of a response from the health care provider.
e. If the patient/parent legal guardian's e-mail requires or invites a response from the health care provider, and the patient/parent/legal guardian has not received a response within a reasonable time period, it is thepatient//parent/

legal guardian's responsibility to call the practice in order to determine whether the intended recipient received the e-mail and when the recipient will respond. As an alternative, the patient/parent/legal guardian can discuss the issue by telephone.

f. The patient/parent/legal guardian should not use e-mail or text messages to discuss any subjects that the patient/parent/legal guardian feels should be kept confidential, such as sensitive medical information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
g. Where applicable, there may be a provider charge for the time necessary to respond to the e-mail.
h. The patient/parent/legal guardian is responsible for protecting his/her password or other means of access to e-mail or text messaging. The health care provider or his/her practice is not liable for information that is read by other people through errors caused by the patient/parent/legal guardian or any third party.
i. The health care provider or his/her practice cannot engage in e-mail or text message communication that is unlawful, such as practicing medicine across state lines.
j. If through e-mail or text message communication, the health care provider determines that an office or hospital visit is necessary to address the problem, or if the patient/parent/legal guardian wants to have such a visit, it is the patient/parent legal guardian's responsibility to schedule the appointment.

## 3. INSTRUCTIONS

To communicate by e-mail or text message, the patient/parent legal guardian is advised to:

a. Limit or avoid use of his/her employer's computer. Information is often stored on the employers system and can be read by people within that organization.
b. Inform the health care provider/practice of changes in e-mail or text messaging addresses.
c. Help the health care provider and/or practice ensure that they are communicating about the right person, put the patient's full name and date of birth in the body of the **first** e-mail message to the provider and/or practice and **not** in the subject line.
d. In order for the e-mail to be forwarded to the proper person, include the category of the communication in the e-mail's subject line, (e.g., "I have a laboratory test question"). For instance, a billing question sent to the doctor may be forwarded to the practice manager.
e. Review the e-mail or text message to make sure it is clear and that all needed information is provided before sending to the health care provider and/or practice.
f. E-mails from health care providers will be encrypted. The first time you receive an email you will get a notice email from ZixCorp and you will have to set up your user name and password with them. This user name and password will be required to access the first and all future emails.
g. Take precautions to preserve the confidentiality of e-mails or text messages, such as using screen savers and safeguarding computer passwords.
h. Withdraw consent only by e-mail or written communication to the health care provider and/or practice.
i. Contact the health care provider and/or practice at their provided telephone number with any questions about using e-mail or text messaging. This should be done before sending an e-mail to the health care provider and/or practice.

## 4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand the information the health care provider and/or practice has provided me regarding the risks of using e-mail or text messaging. I understand the risks associated with the communication of e-mail or text messages between the health care provider and/or practice and me, and consent to the Conditions outlined. In addition, I agree to the above instructions, as well as any other instructions that the health care provider and/or practice may impose regarding e-mail or text message communications.

E-mail address:_____ Cell phone number for texting:

Print Name:_____ Relationship to Patient:_____

Signature:_____ Date:_____ Time:_____

Witness Signature: _____ print name: Date: _____ Time:_____

Office use only:

Second Witness Signature (verbal consent only): Date: Time:_____

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Children's Hospital of The King's Daughters Health System
601 Children's Lane, Norfolk, VA 23507-1910

FOR CHKD OFFICE USE ONLY:
Medical Record #:

## Authorization To Use Or Disclose Protected Health Information-SMPT Community Outreach Services

| PARTICIPANT NAME: (PLEASE PRINT) | DATE OF BIRTH: |
|---|---|
| | |

I AUTHORIZE: Children's Hospital of the King's Daughters Health System (CHKDHS)
601 Children's Lane, Norfolk, VA 23507-1910

TO DISCLOSE: Information about services provided by Sports Medicine Physical Therapy staff and/or the condition of the participant identified above as related to sports activities.

TO: Governor's School for the Arts (GSA)

FOR THE FOLLOWING PURPOSE: At the request of the individual

**NOTE: The purpose is not required if the disclosure is requested by the patient.**

**If the disclosure concerns substance use disorder under the Federal Substance Abuse Confidentiality Requirements, a separate authorization for disclosure of substance use disorder information is required.**

I understand that any disclosure of health information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. **(NOTE: The recipient may be prohibited from re-disclosing substance use disorder information under the Federal Substance Abuse Confidentiality Requirements without my specific written consent.)**

I understand that I may revoke this authorization at any time except to the extent action has been taken in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Health Information Management, Children's Hospital of The King's Daughters, 601 Children's Lane, Norfolk, VA 23507-1910. (The written revocation must be legible and include the name and date of birth of the patient, the date the revocation is to go into effect, a description of the health information covered by the revocation, the person/entity no longer authorized to the receive the information, the signature of the person with legal authority for authorization/revocation, and if not the patient, a description of their legal authority for authorization/revocation, and their phone number.)

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will **expire in one (1) year**.

I understand that I may refuse to sign this authorization and that, in this instance; my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

**CHKDHS IS REQUIRED TO GIVE PATIENT/LEGAL GUARDIAN A COPY OF THIS AUTHORIZATION.**

I certify that I am the patient, the patient's parent or legal guardian with the authority to authorize disclosure of this patient's protected health information.

_____
PRINT NAME OF PATIENT/LEGAL GUARDIAN

_____ _____
SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

_____
RELATIONSHIP TO PATIENT/LEGAL AUTHORITY

SPORTS PERFORMANCE ACADEMY
FITNESS. STRENGTH. WELLNESS.

## Fitness and Sports Performance Programs

Name of Participant: _____ DOB: _____

Address: _____ City: _____ ST: ___ Zip: _____

Parent/Guardian: _____ (H) Phone _____ (C) _____

Email Address: _____

List of sports: _____

List any previous injuries: _____

List any health-related conditions/medications (ie, diabetes, asthma, allergies etc.): _____

_____

## Emergency Contacts and Insurance Information

Emergency Contact: _____ Relation: _____ Phone: _____

Second Emergency Contact: _____ Relation: _____ Phone: _____

## Consent and Waiver Agreement

The Children's Hospital of the King's Daughters (CHKD) fitness and sports performance programs (the "Program") are designed to improve a participant's physical condition, and prepare him for sport participation in a safe, progressive manner at both indoor and outdoor settings. CHKD and its affiliates are not responsible or liable for any injuries resulting from Participant's participation in the Program at any location. I understand that there is risk of injury associated with physical activity both indoors and outdoors, and by signing this agreement, I consent to Participant's participation in the Program at all locations, assume all risks incidental to Participant's participation in the Program at any location, and accept full responsibility for any injuries incurred while participating in this Program at any location. Participant, and any parent or legal guardian acting on behalf of Participant, hereby waives, releases, and agrees to hold CHKD and any of its affiliates, and their officers, agents, and representatives harmless from all liabilities, claims, injuries, losses, damages expenses, demands, actions, and causes of action whatsoever of any of any kind arising directly or indirectly out of Participant's participation in the Program.

## Authorizations and Disclosure of Information Regarding Fitness and Training Activities

As a voluntary Participant in this Program, I hereby authorize the Program and its employees and trainers to provide various fitness and training activities designed to improve my physical condition and prepare me for sport participation in a safe, progressive manner at both indoor and outdoor settings. I further authorize the Program and its employees and trainers to disclose information about my condition and progress relating to the fitness and training activities to the following individual, team organization or team coach, at their request:

_____

_____

Parent or guardian signature is required for each participant under 18 years of age.

By signing below, I confirm that I have read, understand, and agree to the terms and conditions of this Consent and Waiver Agreement.

Signature of Participant _____ Date _____

*If the participant is under 18:* By signing below, I confirm that I have read, understand, and agree to the terms and conditions of this Consent and Waiver Agreement. By signing below, I also give my permission for the minor named above to participate in the Program at both indoor and outdoor settings.

Signature of Parent or Legal Guardian _____ Date _____