

**DocuSign Process for New Patients and Families Fast Track Video Visit
With Shriners Hospitals for Children**

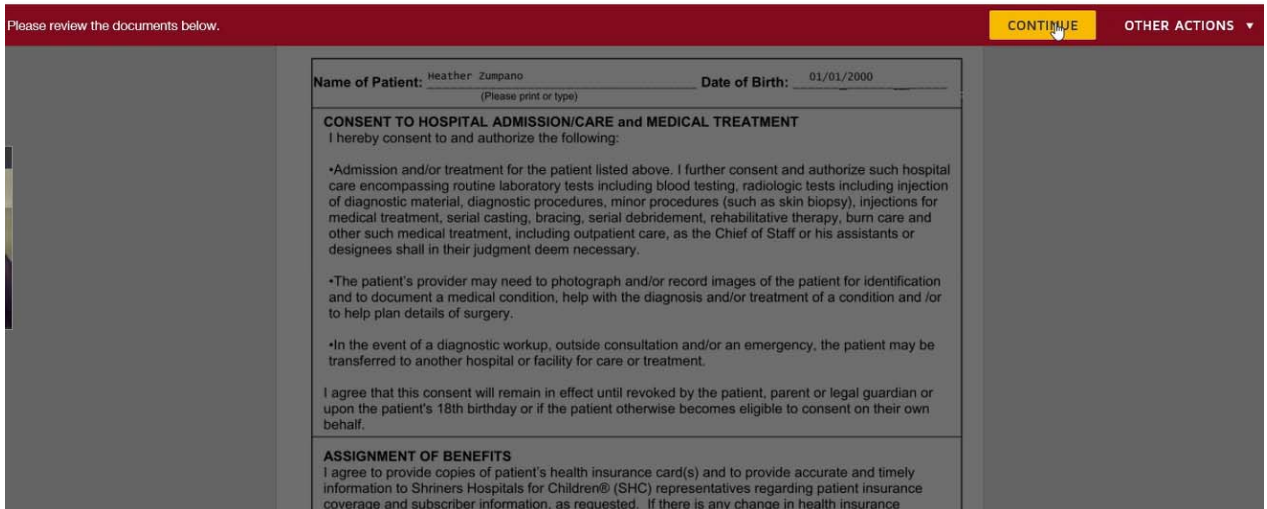
1. Look for the email in your inbox from your patient scheduler's name via DocuSign.



2. Click **Review Documents**.



3. Click **Continue** in the upper right corner.



4. a. Click **View** to Review the Notice of Privacy Practices.

Please review the documents below. **FINISH** OTHER ACTIONS ▾

START **Notice of Privacy Practices** Required - View **VIEW**

This supplement must be read and accepted to complete signing.

DocuSign Envelope ID: 604E9F85-9A0C-4857-B191-E367067AD9B0

Shriners Hospitals
for Children®

Conditions of Care

Name of Patient: Heather Zumpano **Date of Birth:** 01/01/2000
(Please print or type)

CONSENT TO HOSPITAL ADMISSION/CARE and MEDICAL TREATMENT
I hereby consent to and authorize the following:

- Admission and/or treatment for the patient listed above. I further consent and authorize such hospital

- b. Read the entire 8-page document. When you reach the end, click **Accept**.

Shriners Hospitals
for Children®

Shriners Hospitals for Children®

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Read the entire supplement in order to accept. **ACCEPT**

5. a. To sign the Conditions of Care Document, click **Start**. You will see the patient's name and date of birth are pre-filled.

View and accept the supplemental document, as required FINISH OTHER ACTIONS ▾

START **Notice of Privacy Practices** ✓ ACCEPTED VIEW

This supplement must be read and accepted to complete signing.

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Shriners Hospitals for Children

Conditions of Care

Name of Patient: Heather Zumpano Date of Birth: 01/01/2000
(Please print or type)

CONSENT TO HOSPITAL ADMISSION/CARE and MEDICAL TREATMENT
I hereby consent to and authorize the following:

- Admission and/or treatment for the patient listed above. I further consent and authorize such hospital care encompassing routine laboratory tests including blood testing, radiologic tests including injection of diagnostic material, diagnostic procedures, minor procedures (such as skin biopsy), injections for medical treatment, serial casting, bracing, serial debridement, rehabilitative therapy, burn care and other such medical treatment, including outpatient care, as the Chief of Staff or his assistants or designees shall in their judgment deem necessary.
- The patient's provider may need to photograph and/or record images of the patient for identification and to document a medical condition, help with the diagnosis and/or treatment of a condition and/or to help plan details of surgery.
- In the event of a diagnostic workup, outside consultation and/or an emergency, the patient may be transferred to another hospital or facility for care or treatment.

I agree that this consent will remain in effect until revoked by the patient, parent or legal guardian or

- b. 1) Click **Fill-In**. 2) Click **Sign** and either select an electronic signature or draw your own using your computer mouse. 3) Enter your **relationship** to the patient. 4) Enter your valid email address.

Enter text FINISH OTHER ACTIONS ▾

This document will remain in effect for subsequent outpatient Services provided by SHC until revoked in writing by the undersigned, or upon the patient's 18th birthday, at which time a new form will need to be completed. In addition, a new form will be signed for all outpatient surgeries and inpatient admissions. I/we certify that I am/we are the natural or adoptive parents or legal guardian of the patient named above, and that I am/we are legally authorized to consent to the medical care of the patient. I/we agree to notify the hospital if there is any future change in this relationship, and to provide documentation to confirm such relationship, if requested.

I/we understand that I am/we are responsible for payment of any copay, deductible or coinsurance that the applicable insurance requires in connection with Services provided to the patient.

The information supplied to SHC is true, accurate and complete to the best of my/our knowledge.

Sign Date: 4/28/2020 | 9:20 AM RT Time: _____

Patient, Parent or Legal Guardian Signature Required - Relationship to Patient
christinedrake

Patient, Parent or Legal Guardian (print name) Relationship (if not signed by the patient)

Witness Signature Date: _____ Time: _____

Witness (print name) Witness Address

Patient, Parent or Legal Guardian Signature Date: _____ Time: _____

Patient, Parent or Legal Guardian (print name) Relationship (if not signed by the patient)

Date: _____ Time: _____

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c. Your Conditions of Care Document is complete. Click **Next**.

Enter email address FINISH OTHER ACTIONS ▾

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inpatient admissions. I/we certify that I am/we are the natural or adoptive parents or legal guardian of the patient named above, and that I am/we are legally authorized to consent to the medical care of the patient. I/we agree to notify the hospital if there is any future change in this relationship, and to provide documentation to confirm such relationship, if requested.

I/we understand that I am/we are responsible for payment of any copay, deductible or coinsurance that the applicable insurance requires in connection with Services provided to the patient.

The information supplied to SHC is true, accurate and complete to the best of my/our knowledge.

DeSigned by: Christine Drake Date: 4/28/2020 | 9:23 AM PDT Time: _____

Patient, Parent or Legal Guardian Signature Mother

Christine Drake Relationship (if not signed by the patient)

cdrake@shrinenet.org Date: _____ Time: _____

Witness Signature _____

Witness (print name) _____ Witness Address _____

_____ Date: _____ Time: _____

Patient, Parent or Legal Guardian Signature _____

_____ Relationship (if not signed by the patient)

_____ Date: _____ Time: _____

Witness Signature _____


Witness (print name) _____ Witness Address _____

NEXT

6. Click **View** to Review the Email Communication Supplemental Agreement.


Email Communication Supplemental Agreement

This supplement must be viewed, scrolled to end, and accepted.

View 


7. Read the agreement, then click **Accept**.

DocuSign Envelope ID: 83ED1F00-C84D-4F06-B3BF-ACDD8E5613A8

 **Shriners Hospitals for Children**

By providing us with your e-mail address below, you are giving us permission to use this address to electronically communicate patient information as well as other administrative information necessary for us to provide services to the patient.

1 of 1

 **Shriners Hospitals for Children** **Informed Consent for Telehealth Services**

I, or the undersigned, as the parent(s) or legal guardian of David L Long understand:
(Print Name and Date of Birth of Patient)

1. I, or (if the undersigned is the parent or legal guardian of the patient) my child, may receive telemedicine or telehealth (hereinafter collectively "Telehealth") services from Shriners Hospitals for Children and/or its staff (hereinafter "SHC") at an offsite clinic location, or directly through access provided by the SHC patient portal or other electronic means.

I have read and I accept this supplement. **ACCEPT**

8. After the Email Agreement is completed, you will be taken to the Telehealth Informed Consent document. Notice the patient's name and date of birth are already completed. Click **Next**.

View and accept the supplemental document, as required **FINISH** **OTHER ACTIONS**


Witness (print name) Witness Address
Heather Zumpano
01/01/2000 1234567
Tampa
Form 1202 12/2017 Page 3 of 3

Form_1202_Conditions_of_Care_12-2017_ENG.pdf 3 of 3

NEXT **Email Communication Supplemental Agreement** ✓ ACCEPTED **VIEW**

This supplement must be read and accepted to complete signing.

DocuSign Envelope ID: 604E9F85-9A0C-4857-B191-E367067AD9B0

 **Shriners Hospitals for Children** **Informed Consent for Telehealth Services**

Heather Zumpano
I, or the undersigned, as the parent(s) or legal guardian of 01/01/2000 understand:
(Print Name and Date of Birth of Patient)

1. I, or (if the undersigned is the parent or legal guardian of the patient) my child, may receive telemedicine or telehealth (hereinafter collectively "Telehealth") services from Shriners Hospitals for Children and/or its staff (hereinafter "SHC") at an offsite clinic location, or directly through access provided by the SHC patient portal or other electronic means.

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9. The signature, relationship to the patient, and email address fields will already be completed. Click **Finish**.

Done! Select Finish to send the completed document. **FINISH** OTHER ACTIONS ▾

- I have read or had this form read and/or had this form explained to me.
- I fully understand its contents, including the risks and benefits of Telehealth services offered to me or my child, and
- I will not proceed with the Telehealth services unless all of my questions or concerns are answered to my satisfaction.

DocuSign: **Christine Drake** 4/28/2020 | 9:25 AM PDT
Signature of Patient/Parent/Legal Guardian Date/Time Signature of Patient/Parent/Legal Guardian Date/Time

Christine Drake **Mother**
Print Name and Relationship to Patient Print Name and Relationship to Patient

cdrake@shrinenet.org
Print Name and Relationship to Patient

Informed Consent for Telehealth Services Heather Zumano
Shriners Hospitals for Children® 01/01/2000 1234567
*Except Texas Tampa

Form #TIC1 03/2020 Page 2 of 2

Telehealth-Informed-Consent-0-2020.pdf 2 of 2

FINISH

10. You are finished! The window below will appear, and you can simply click **No Thanks**.

Log in to DocuSign

A copy of this document has been saved to your DocuSign account. Please log in to view it.

Email
cdrake@shrinenet.org

LOG IN **NO THANKS**