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.

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

   ![Start button](image)

   Notice of Privacy Practices
   This supplement must be read and accepted to complete signing.

   Conditions of Care

   Name of Patient:   [Redacted]  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.
   - 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 biopsies), injections for medical treatment, serial casting, bracing, serial detumescence, rehabilitative therapy, bum 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

   ![DocuSign Environment](image)

   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**.

   ![Fill-In button](image)

   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/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.

   ![Signature](image)

   Patient, Parent or Legal Guardian Signature
   (Please print or type)

   Witness Signature

   Witness (print name)  Witness Address
   (Please print or type)

   ![Finish button](image)

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

6. Click **View** to Review the Email Communication Supplemental Agreement.
7. Read the agreement, then click **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**.
9. The signature, relationship to the patient, and email address fields will already be completed. Click 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