

## Proceso de DocuSign para que pacientes y familias nuevos utilicen el sistema de videoconsulta

### Fast Track Video Visit con los Hospitales Shriners para Niños

1. Busque el mensaje de correo electrónico en su casilla, enviado por el coordinador de pacientes a través de DocuSign.

Heather Zumpano via DocuSign  
[Ext] Please DocuSign: Shriners Hospitals for Children... 12:13 PM

2. Haga clic en **Review Documents** (Revisar documentos).



3. Haga clic en **Continue** (Continuar), en la esquina superior derecha.

Please review the documents below.

**CONTINUE** OTHER ACTIONS ▾

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 upon the patient's 18th birthday or if the patient otherwise becomes eligible to consent on their own behalf.

**ASSIGNMENT OF BENEFITS**  
I agree to provide copies of patient's health insurance card(s) and to provide accurate and timely information to Shriners Hospitals for Children® (SHC) representatives regarding patient insurance coverage and subscriber information, as requested. If there is any change in health insurance


4. a. Haga clic en **View** (Ver) para revisar el Aviso de prácticas de privacidad.

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. Lea el documento de 8 páginas en su totalidad. Cuando llegue al final, haga clic en **Accept** (Aceptar).

  
**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. Para firmar el documento Condiciones de atención, haga clic en **Start** (Comenzar). Verá que el nombre y la fecha de nacimiento del paciente ya están completados.

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.

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 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) Haga clic en **Fill-In** (Rellenar). 2) Haga clic en **Sign** (Firmar) y seleccione una firma electrónica o firme usted mismo usando el mouse de la computadora. 3) Indique su **relación** con el paciente. 4) Indique una **dirección de correo electrónico válida**.

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 18<sup>th</sup> 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 PDT Time: \_\_\_\_\_

Patient, Parent or Legal Guardian Signature Required - Relationship to Patient  
Christine Drake \_\_\_\_\_

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. El documento Condiciones de atención está listo. Haga clic en **Next** (Siguiente).

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 PM Time: \_\_\_\_\_  
Patient, Parent or Legal Guardian Signature

Christine Drake Relationship (if not signed by the patient) Mother

Patient, Parent or Legal Guardian (print name) Relationship (if not signed by the patient)  
cdrake@shrinenet.org Date: \_\_\_\_\_ Time: \_\_\_\_\_

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)

\_\_\_\_\_  
Witness Signature Date: \_\_\_\_\_ Time: \_\_\_\_\_


\_\_\_\_\_  
Witness (print name) \_\_\_\_\_ Witness Address \_\_\_\_\_

NEXT

6. Haga clic en **View** (Ver) para revisar el Acuerdo complementario de comunicación por correo electrónico.

**Email Communication Supplemental Agreement**

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

View 

7. Lea el acuerdo y, a continuación, haga clic en **Accept** (Aceptar).

DocuSign Envelope ID: 83ED1F00-C84D-4F06-B3BF-ACD0E5613A8

**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.

Email Communication Supplemental Agreement SF-ACD0E5613A8 1 of 1

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

I, or the undersigned, as the parent(s) or legal guardian of Davi 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. Una vez completado el acuerdo por correo electrónico, se lo dirigirá al documento de Consentimiento informado para telemedicina. Observe que el nombre y la fecha de nacimiento del paciente ya están completados. Haga clic en **Next** (Siguiente).

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

Witness (print name) Witness Address

Heather Zumpano  
01/01/2000 1234567  
Tampa

**Conditions of Care**  
Shriners Hospitals for Children  
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**NEXT** **Email Communication Supplemental Agreement** ✓ ACCEPTED **VIEW**

This supplement must be read and accepted to complete signing.

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**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. Los campos de firma, relación con el paciente y dirección de correo electrónico ya estarán completados. Haga clic en **Finish** (Terminar).

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. ¡Listo! Aparecerá la ventana que se muestra a continuación, donde simplemente podrá hacer clic en **No Thanks** (No, gracias).

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**