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 (Please print or type) Date of Birth: 01/01/2000

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.

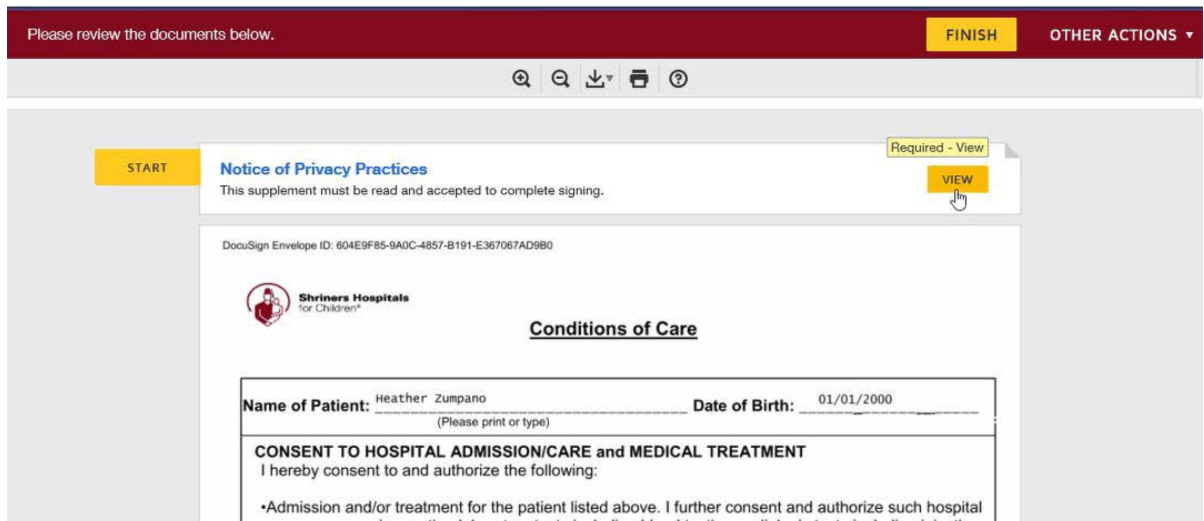
•The patient's provider may need to photograph and/or record images of the patient for identification and to document a medical condition, help with the diagnosis and/or treatment of a condition and /or to help plan details of surgery.

•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.

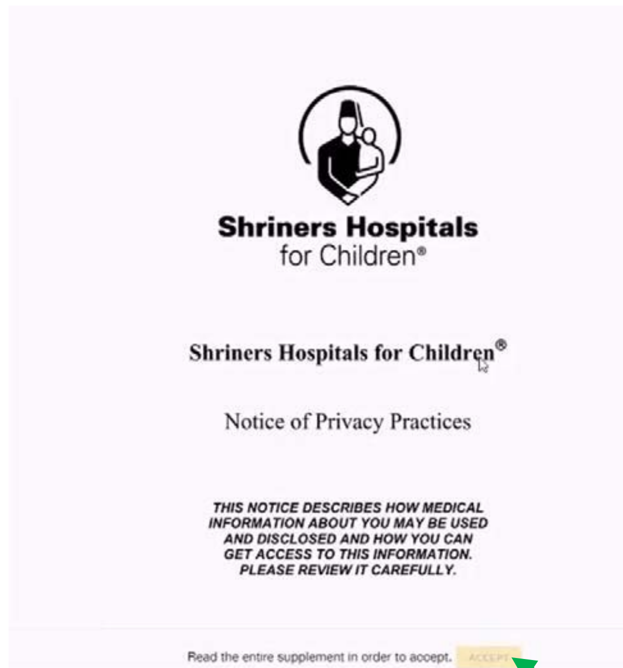
I agree that this consent will remain in effect until revoked by the patient, parent or legal guardian or upon the patient's 18th birthday or if the patient otherwise becomes eligible to consent on their own behalf.

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.



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



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
This supplement must be read and accepted to complete signing. ACCEPTED VIEW

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

Shriners Hospitals for Children

Conditions of Care

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

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

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•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 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 PDT Time:

Patient, Parent or Legal Guardian Signature

Required - Relationship to Patient

FILL IN

Christine Drake

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

Date: Time:

Witness Signature

Witness (print name) Witness Address

Date: Time:

Patient, Parent or Legal Guardian Signature

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 ▾

NEXT

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.

DocuSigned by: Christine Drake Date: 4/28/2020 | 9:23 AM PDT Time: ________
Patient, Parent or Legal Guardian Signature

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

cdrake@shrinenet.org
________________________________ Date: ____________ Time: ________
Witness Signature

____
Witness (print name) Witness Address

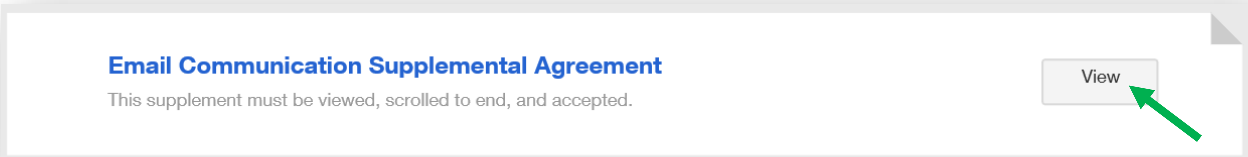
________________________________ Date: ____________ Time: ________
Patient, Parent or Legal Guardian Signature

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

________________________________ Date: ____________ Time: ________
Witness Signature

____
Witness (print name) Witness Address

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



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

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).

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

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