Tulane Center for Autism and Related Disorders

Tulane Medical Center Hospital and Clinic

Thank you for your interest in the Tulane Center for Autism and Related Disorders (TCARD). Please review carefully and complete the enclosed paperwork. The detailed information you include on the intake form will aid our team in the evaluation process. Once completed, please return all forms to our office by fax, email, or mail. After receipt of completed forms, the patient will be placed on our waiting list for an appointment. You may contact the office for information on the patient's wait list position. We look forward to meeting your family and providing the best possible services for your needs.

Fax: 504-988-0496

Scan and Email: autism@tulane.edu

Mail: Tulane Center for Autism and Related Disorders
1430 Tulane Ave.
#8055
New Orleans, LA 70112

Drop off at office: Tulane Center for Autism and Related Disorders
131 S. Robertson St., 14th floor
New Orleans, LA, 70112

In order to schedule an appointment for your child, **you must complete the entire packet including the details of your child's insurance plan** (page 17) if no copy of the card is included. If your child has Medicaid, *please include the name of the plan and your child's ID number*.

If you have any questions please call 504-988-3533 or email autism@tulane.edu

TCARD - PARENT QUESTIONNAIRE CASE HISTORY

Today's Date: _____ Referred by: _____

Person completing questionnaire: _____

Relationship to the child: _____

IDENTIFYING INFORMATION AND FAMILY BACKGROUND

Name of Child: _____
(First) (Middle) (Last) (Nickname)

Date of Birth: ____/_____/_____Age: _____ Gender

Social Security #:_____

Ethnicity (circle): Black/African American Hispanic/Latino White/Caucasian
Asian/Pacific Islander Native American Other (specify)_____

Mother/Caregiver: _____
(First) (Middle) (Last) (Nickname)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (_____) _____-_____Work: (_____) _____-_____Cell: (_____) _____-_____

Email: _____

Father/Caregiver: _____
(First) (Middle) (Last) (Nickname)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (_____) _____-_____Work: (_____) _____-_____Cell: (_____) _____-_____

Email: _____

Preferred Method of Contact: (circle)

- Home phone
- Cell phone
- Work phone
- Email

Please attach a recent photo of your child for use in our permanent file

Are the child's parents Divorced/Separated? ☐ Yes ☐ No

If Divorced/Separated:

Who is responsible for making medical decisions for the child? _____

Who is the domiciliary parent? _____

Whom does the child primarily reside with? ☐ Mother ☐ Father ☐ Other

Are both parents aware of services being sought at the Autism Center? ☐ Yes ☐ No

Does your child have a Guardian Ad Litem? ☐ Yes ☐ No

If yes, name: _____

Please provide all court documents and/or parenting plans prior to your first appointment

Please provide names and relationships of parents/guardians caring for the child:

_____

Parent's language preference: _____

Child's language preference: _____

Primary Pediatrician: _____

City, State: _____ Phone: _____

Other Healthcare Provider & Specialty: _____

City, State: _____ Phone: _____

Other Healthcare Provider & Specialty: _____

City, State: _____ Phone: _____

Other Healthcare Provider & Specialty: _____

City, State: _____ Phone: _____

PURPOSE OF EVALUATION

1. Who referred the patient to TCARD and for what reason?

2. What are your questions or concerns regarding your child?

3. When did you first become concerned about your child?

PREGNANCY HISTORY

This section is to be completed by the mother of the child, if possible. Please indicate who completed it if by another person: _____

Did mother receive any assisted reproductive technology? ☐ Yes ☐ No ☐ Unsure

Was this child a planned pregnancy? _____

This child was pregnancy number _____

This child was delivery number _____

Number of pregnancies you have had _____

Number of live births _____

Number of stillbirths _____

Number of miscarriages _____

Number of living children _____

Number of deceased children _____

PREGNANCY & PERINATAL HISTORY

Age of mother at delivery: _____ Age of father at delivery: _____

Did you receive regular medical care during this pregnancy? ☐ Yes ☐ No

Did you have any health problems during this pregnancy? ☐ Yes ☐ No

If yes, please describe the problem and the time it occurred during the pregnancy (such as abdominal trauma, infections, high blood pressure, diabetes, bleeding, weight loss, accidents, fever, etc.):

Did you take any medication during this pregnancy? ☐ Yes ☐ No

If yes, please list:

Did you smoke during this pregnancy? ☐ Yes ☐ No

If yes, please list how many cigarettes per day: _____

Did you use alcohol or other drugs during this pregnancy? ☐ Yes ☐ No

If yes, please describe your use (i.e., what and how often):

LABOR AND DELIVERY

Was your baby carried a full 9 months? ☐ Yes ☐ No

If no, please indicate the length of the pregnancy: _____

Was this child a product of a multiple birth pregnancy (e.g. twins, triplets)? ☐ Yes ☐ No

If yes, was the child A, B, C, etc.? _____

Type of delivery (circle): ☐ Vaginal ☐ C- Section

Reason for C-Section: _____

Any problems/complications with delivery:_____

Where was this child born? _____

(Hospital) (City)

How long did the labor last? _____

Was Pitocin or other medication used to induce or augment this labor? ☐ Yes ☐ No ☐ Unsure

How much did your baby weigh at birth? ____ lb____ oz

Was the child admitted to the NICU (neonatal intensive care unit)? ☐ Yes ☐ No

For what reason? _____

How old was your child when discharged from the NICU: ___ ___ ___ days

Did your baby need any special care during the first few days? ☐ Yes ☐ No

If yes, please describe:

PAST MEDICAL HISTORY

Does the patient have any medical diagnoses? ☐ Yes ☐ No

If yes, provide **name** of diagnosis and **date** diagnosed:

_____

_____

_____

Current Medications: ☐ None

Medication Name:	Dosage:	Purpose:	Prescribing Dr.:

Has the patient ever (attach pages if necessary):

		Date:	Reason
Been Hospitalized	☐ No ☐ Yes		
Had Surgery	☐ No ☐ Yes		

Are your child's immunizations up to date? ☐ Yes ☐ No ☐ Unsure

Has the patient had any of the following evaluations?

Evaluation	No	Yes		If Yes, Date:	If yes, Result:
Audiologic/Hearing Test	☐	☐			
Vision Test	☐	☐			
Head Imaging (MRI, CT, etc.)	☐	☐			
EEG	☐	☐			
Genetic Testing	☐	☐			
Other, Specify:	☐	☐			

DEVELOPMENTAL HISTORY

Does your child:	No	Yes	Age achieved
Sit unsupported	☐	☐	
Crawl	☐	☐	
Walk independently	☐	☐	
Single words	☐	☐	
Combine words	☐	☐	
Use simple sentences	☐	☐	
Use complex sentences	☐	☐	

Is your child toilet trained? ☐ Yes ☐ No ☐ Partially

If yes, at what age? _____

If partially, which can your child do in toilet: ☐ urinate alone ☐ urinate when reminded/told ☐ defecate alone ☐ defecate when reminded/told

Does your child have toileting accidents during the day? ☐ Yes ☐ No

If yes, how often? _____

Has your child ever lost any skills or gone backwards in development? ☐ Yes ☐ No

If yes, please explain:

ADOLESCENT DEVELOPMENT

****This section is to be completed if the child in question has reached puberty.**

Has your child started puberty?		☐ Yes ☐ No
For boys, has your son:	voice change?	☐ Yes ☐ No
	Using deodorant?	☐ Yes ☐ No
	Hair under arms?	☐ Yes ☐ No
	Pubic hair?	☐ Yes ☐ No
	Testicle/penis growth?	☐ Yes ☐ No
For girls, has your daughter:	developed breasts?	☐ Yes ☐ No
	Shaving legs/arm pits?	☐ Yes ☐ No
	Using deodorant?	☐ Yes ☐ No
	Started period?	☐ Yes ☐ No

Has your child engaged in any sexual activity? ☐ Yes ☐ No

Has your child done any of the following:

Drank alcohol?	☐ Yes	☐ No
Used drugs to get high?	☐ Yes	☐ No
Smoke cigarettes?	☐ Yes	☐ No
Drink caffeine?	☐ Yes	☐ No

BEHAVIORAL/PSYCHIATRIC HISTORY

Does the patient have any psychiatric diagnoses? ☐ Yes ☐ No
If yes, provide **name** of diagnosis and **date** diagnosed:

_____

_____

_____

Does your child tend to worry? ☐ Yes ☐ No
If yes, please explain:

Do you have any concerns about the management of your child's behavior at home? ☐ Yes ☐ No
If yes, please explain:

How do you discipline your child?

Are your discipline methods effective? ☐ Yes ☐ No
If no, please explain:

How does your child respond to frustration?

What toys or activities does your child enjoy?

What do you consider to be your child's strengths?

Please place a check in the appropriate box that best describes the child's behavior.

Check only one box for each line please.	Degree of Activity			
	Not at all	Just a little	Pretty much	Very much
Restless or overactive	○	○	○	○
Excitable, impulsive	○	○	○	○
Disturbs other children	○	○	○	○
Fails to finish things started/short attention span	○	○	○	○
Consistently fidgeting	○	○	○	○
Inattentive, easily distracted	○	○	○	○
Demands must be met immediately/easily frustrated	○	○	○	○
Cries often and easily	○	○	○	○
Mood changes quickly and drastically	○	○	○	○
Temper outbursts, explosive and unpredictable behavior	○	○	○	○

FAMILY HISTORY

Instructions: The questions below ask about the family history of the child. Please indicate if there is a family history of the disorder. If "yes," indicate which family member(s). Include only **biological (blood) relatives**.

Disorder	*No*	*Yes*	*Family member with diagnosis (write in)*
Autism Spectrum Disorder	☐	☐	
Intellectual Disability (formerly known as Mental Retardation)	☐	☐	
Speech language disorder (received speech therapy)	☐	☐	
ADHD/ADD	☐	☐	
Obsessive Compulsive Disorder	☐	☐	
Anxiety Disorder	☐	☐	
Depression	☐	☐	
Manic depression or Bipolar disorder	☐	☐	
Schizophrenia	☐	☐	
Seizures	☐	☐	
Neurofibromatosis	☐	☐	
Auto-immune disorders (e.g. Lupus, Rheumatoid Arthritis, Multiple Sclerosis)	☐	☐	
Neurologic disease (e.g. Parkinson's, Huntington's Disease)	☐	☐	

Disorder	*No*	*Yes*	*Family member with diagnosis (write in)*
Genetic disorder Specify:	☐	☐	
Other:	☐	☐	

EDUCATIONAL HISTORY

Did your child attend preschool? ☐ Yes ☐ No

Child's current grade placement: _____

Current school name & address: _____

Has your child repeated a grade? ☐ Yes ☐ No

If yes, which grade(s) was repeated? _____

Grade	School (with city & state) *Complete as far as child has progressed in school—if child has repeated a grade and changed schools, please write both in the line*
K	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	

Have you requested an evaluation through your child's school? ☐ Yes ☐ No

If yes, when? _____

If yes, did your child receive testing? ☐ Yes ☐ No

Does your child have special accommodations?: ☐ IEP ☐ 504 Plan ☐ Neither

If yes, **PLEASE PROVIDE COPY OF THE IEP/504.**

FAMILY DATA

Biological Mother's Information: Age: _____ Highest Grade Completed: _____

Occupation: _____ (circle one): Full-time Part-time

Place of Employment: _____

Biological Father's Information: Age: _____ Highest Grade Completed: _____

Occupation: _____ (circle one): Full-time Part-time

Place of Employment: _____

Caregiver 1 Information (if different from above):
Relation to child (circle): Foster Adoptive Step-Parent
Relative/Other (specify):_____

Age: _____ Highest Grade Completed: _____

Occupation: _____ (circle one): Full-time Part-time

Place of Employment: _____

Caregiver 2 Information (if different from above):
Relation to child (circle): Foster Adoptive Step-Parent
Relative/Other (specify):_____

Age: _____ Highest Grade Completed: _____

Occupation: _____ (circle one): Full-time Part-time

Place of Employment: _____

Parent/Caregiver Relationship Status:

Single Divorced Widowed

Married (if married, to whom/relationship to child):_____

In a relationship, not married (if yes, to whom/relationship to child): _____

Is the child a foster child? Yes No
If yes, length of time in your home: _____
Is child adopted? Yes No

If yes, age at adopted: _____

If child is foster child or adopted, has this been discussed with your child? ☐ Yes ☐ No

Who has legal guardianship of the child? _____

Please list all persons presently living in primary caregivers home:

	Name	Sex	Birthdate	Relation to child	Grade/degree
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

If child splits time between homes,

What is child's visitation schedule in other caregivers home? _____

_____

Please list all person's presently living in other caregivers home:

	Name	Sex	Birthdate	Relation to child	Grade/degree
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Has the child ever experienced a traumatic event?	Yes	No
Emotional abuse (e.g. verbal threats, belittling)	☐	☐
Physical abuse	☐	☐
Sexual abuse	☐	☐
Neglect (not being fed, clothed, sheltered, cared for appropriately)	☐	☐
Exposure to domestic violence	☐	☐
Exposure to drug abuse	☐	☐
Exposure to violence in neighborhood	☐	☐
Parent/Caregiver incarceration	☐	☐
Experienced life-threatening event (e.g. car accident, natural disaster)	☐	☐
Intercountry migration due to violence, adverse conditions, etc.	☐	☐
Death of a loved one Specify relationship to child: _____	☐	☐

If yes to any of the above, please briefly explain:

Thank you for completing this questionnaire.

Please return via mail, email, or fax:

Tulane Center for Autism and Related Disorders
1430 Tulane Ave. #8055
New Orleans, LA 70112

Autism@tulane.edu

Fax: 504-988-0496

TULANE CENTER FOR AUTISM AND RELATED DISORDERS

504.988.3533 phone | 504.988.0496 fax | autism@tulane.edu

Dear Family,

At TCARD, we are committed to providing our families with comprehensive and integrated care that focuses on the child as a whole. We want to assist your child's pediatrician with providing similarly informed care. By singing this release of information, you are allowing TCARD to notify your child's pediatrician of the up-coming evaluation and the results of the evaluation once it has been conducted. Your child deserves the best in care, which is developed through collaborative relationships among treatment providers. Thank you for helping us to provide the best care for your family. Please return this form with your completed intake packet.

Sincerely,

Team TCARD

Child's Pediatrician: _____

Practice Fax Number:_____

Practice Address: _____

I, _____, parent/guardian of _____, grant permission to TCARD to release information regarding my child's up-coming appointment and the results of any evaluations/treatment plans developed specifically for my child. If there is any information required by TCARD from the pediatrician's office, I also grant permission for them to access those records.

_____ _____

Parent/Guardian Signature Date

Tulane Medical Center Hospital and Clinic

PRE-REGISTRATION

Please finish the pre-registration forms as completely as possible and attach a copy of your insurance card. No appointment can be scheduled without this information

Patient's Name_____
last first middle maiden

Address_____
number, street, apt city, state zip code

Parish or County_____ Patient's Home Phone(_____)_____
area code

Date of Birth_____Patient's Age_____Patient's Soc. Sec. No._____

Patient's Sex_____Marital Satuts_____Race_____

Patient's Religion_____Patient's Employer_____

Patient's Employer's Address_____
number, street, apt city, state zip code

Patient's Business Phone(_____)_____Patient's Occupation_____
area code

Employment Status_____full time_____part time_____retired_____self-employed

Referring Physician_____Phone_____

Guarantor: (Person Responsible for Bill)

Name_____Soc. Sec. No._____

Address_____
number, street, apt city, state zip code

Home Phone(____)_____Date of Birth_____Sex_____Relationship_____
area code

Employer_____Address_____
number, street, apt

_____Business Phone(_____)_____
city, state zip code area code

Occupation_____Date or length of employment_____

Employment Status_____full time_____part time_____retired _____self-employed

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Next of Kin:

Name_____Soc. Sec. No._____Home Phone(_____)_____
area code

Address_____Date of Birth_____
number, street, apt city, state zip code

Relationship_____Employer_____

Employer's Address_____Business Phone(_____)_____
area code

Occupation_____ Empl. Status___full time___part time____retired___self-empl.

In case of Emergency, please notify: Name_____
Phone (_____)_____Relationship_____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

Insurance Company's Name_____Address_____

Phone Number (_____)_____ Is this through your employment? YES NO

If so, what is the employer's name_____Phone(_____)_____

Employee ID#_____Group Name_____

Contract or Individual #_____Group #_____

Policyholder's Name _____Relationship to patient_____

SECONDARY INSURANCE CARRIER

Insurance Company's Name_____Address_____

Phone Number (_____)_____ Is this through your employment? YES NO

If so, what is the employer's name_____Phone(_____)_____

Employee ID#_____Group Name_____

Contract or Individual #_____Group #_____

Policyholder's Name _____Relationship to patient_____

WORKMAN'S COMENSATION / THIRD PARTY BILLING

Name_____

Address_____

Phone (_____)_____Ext_____

Confirmed by_____Title_____Date_____

MEDICARE ELIGIBILITY DETERMINATION

Part I. WORKMAN'S COMPENSATION
Was your illness/injury due to a work related accident/condition? Yes_____ No _____
Is your condition covered by Workmen's Compensation plan or the Federal Black Lung Program?Yes No
Part II. ACCIDENT
Was your illness/injury due to an accident? Yes_____ No _____
Part III. ESRD/KIDNEY DIALYSIS
Are you age 65 or over? Yes_____ No _____
Are you undergoing kidney dialysis for ESRD? Yes_____ No _____
Part IV. DISABILITY
Are you a disabled Medicare beneficiary under age 65? Yes_____ No _____
Part V. EMPLOYER'S GROUP HEALTH PLAN
Are you or your spouse employed and participating in the Employer's Group Health Plan? Yes_____No_____

MEDICARE ELIGIBITY: MEDICARE PRIMARY_____ SECONDARY_____

Patient/Parent Signature_____ Date_____

Interviewed by_____

TCARD Policy and Procedure for
No Shows and Late Cancellations

No-shows and late cancellations are very disruptive to the clinic schedule. When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient and increases waiting list times. No-shows and late cancellations delay the delivery of services to other patients, some who are in great need. Below are the policies and procedures that we have implemented regarding these situations.

A "no-show" is missing a scheduled appointment without any notification prior to the start of the appointment time. A "late cancellation" is cancelling an appointment without calling us to cancel 24 hours in advance of an intake and feedback or 48 hours in advance of a testing appointment.

INTAKE APPOINTMENTS

New clients who no-show for their first appointment will NOT be automatically rescheduled. Less than 24 hours advance notice for intake appointments will be considered a no-show. Monday appointments must be cancelled by the Friday before the appointment. Consideration of extraordinary circumstances with proper documentation will occur on a case by case basis. (No-show fees *may* apply.) If the new client initiates a phone call requesting to be rescheduled after their first no-show, they may first be returned to the waiting list. If the new client no-shows for an intake a second time, they will not be rescheduled and will have to seek services elsewhere.

TESTING APPOINTMENTS

Less than 48 hours advance notice of cancellation for testing will be considered a no-show. Monday appointments must be cancelled by the Friday before. If there is a no-show for testing, the client may NOT be rescheduled. Consideration of extraordinary circumstances with proper documentation will occur on a case by case basis. No-show fees *may* apply.

FEEDBACK APPOINTMENTS

Less than 24 hours advance notice for feedback appointments will be considered a no-show. Monday appointments must be cancelled by the Friday before the appointment. Consideration of extraordinary circumstances with proper documentation will occur on a case by case basis. If a client no-shows for a feedback appointment, they will not be rescheduled and the final report will be mailed to the caregiver.

No-show/late cancellation fees are the FULL responsibility of the client—insurance companies do not pay for missed appointments.

By signing below, you are agreeing to the terms of this policy and you understand your responsibility in making scheduled appointments.

_____ _____

Signature Date

_____

Printed Name & Relationship to Child

EMAIL CONSENT FORM

If you wish to correspond with via electronic mail (email) please read and sign the following. This form provides guidelines for the intended use of this type of communication, and documents your consent.

IN A MEDICAL EMERGENCY, DO NOT USE EMAIL. CALL 911

E-mail Use:	Generally, e-mail correspondence should be between the provider and an adult patient 18 years or older, or parent or legal guardian of a minor.
Privacy and Confidentiality:	Unless your provider tells you specifically that the e-mail will be conducted via a secure server, consider e-mail like a postcard that can be viewed by unintended persons. In addition, the content of the email may be monitored by the hospital to ensure appropriate use. Discuss with your provider who will process your e-mail messages during business hours, vacations or illness. All e-mails regarding your care will be included in your medical record.
Creating a Message:	On the "Subject" line, include the general topic of the message, for example, Prescription of Appointment or Advice. In the body of the message, include your name.
Content of The Message:	E-mail should be used only for non- sensitive and non-urgent issues. Types of information appropriate for e-mail include: • Questions about resources • Routine follow-up inquiries • Appointment scheduling
Ending E-mail Relationship	Either you or your provider may request via e-mail or letter to discontinue using e-mail as a means of communication.

Disclaimer: Tulane Center For Autism And Related Disorders And Tulane University Medical Group are not responsible for e-mail messages that are lost due to technical failure during composition, transmission and /or storage.

I have read and understand the information above, and had any questions answered to my satisfaction. I agree to the guidelines for e-mail communication.

_____	_____	_____
Date	Signature of patient, parent or Personal representative	Relationship (if other than patient)

Patient E-mail address (please print): _____

Provider Name: _____ Phone Number: _____

Provider E-mail address (please print): _____

CONSENT TO BE CONTACTED FOR FUTURE RESEARCH

What is the purpose of this consent? The providers in the TCARD Clinic are doing research that is designed to lead to better treatments for the types of problems experienced by the people who come to this clinic. They want to know if you wish to learn more about their research studies of if you may wish to participate in any of the studies that may be appropriate for you. By signing this form, you will allow qualified professional people on the staff on this clinic to contact you in the future to ask if you want to participate in any studies. You have no obligation to actually participate in any study.

What happens if I sign this form? If you sign this form, you are giving consent for information to be taken from your TCARD medical records. This list includes information about your diagnosis, your name, medical record number, date of birth, diagnosis and contact information. This information will be kept indefinitely, unless you withdraw your permission. If a study on your condition needs subjects, you may be contacted to ask if you want to participate. You do not have to participate. You may withdraw permission to be contacted at any time by contacting the clinic.

What happens if I don't sign this form? Declining to participate will have no influence on your present or future status as a patient in this clinic. You will receive the same care as any other patient seen in this clinic. There will be no penalty or loss of benefits to which you are otherwise entitled. Your clinic records will indicate that you do not want to be asked about future research by or through anyone but your treating physician.

Are there any risks to my signing this form? Participation in research may involve some loss of privacy. However, your records will be handled as confidentially as possible. Access will be limited to the data manager and the doctor organizing the study and will require a password. No information will be used for research without additional permission. Your contact information will not be shared with anyone outside this clinic.

Are there any financial considerations? There will no cost or payment to you if you sign this form.

What do I do if I have questions, now or later? You can talk with the study researcher about any questions, concerns or complaints you have about this study. Contact the study researcher(s) Lisa Settles, Psy.D. at 504-988-8533

If you wish to ask questions about the study or your rights as a research participant to someone other than the researchers or if you wish to voice any problems or concerns you may have about the study, please call the office of the Institutional Review Board at 504-865-5000. [If there are additional informational sources related to the study (e.g., patient representatives or individuals at other study sites as appropriate), list here with contact information.]

What do I do to consent? If you agree to be contacted in the future, please indicate your preferred contact method and sign below.

Preferred contact method:

☐ Phone: _____
☐ Mail: _____
☐ Email address: _____

_____ _____
Signature Date

_____
Signature of Person Obtaining Consent Date

TUMG CONSENT AND RELEASE

ASSIGNMENT OF BENEFITS: I authorize direct payment to Tulane University Medical Group ("TUMG"), of all medical benefits, settlements, or judgments applicable to my treatment by TUMG physicians and other clinicians at the hospital or clinic. This authorization is applicable to all future charges and fees from, and including, this day forward, unless revoked in writing by me. I understand that I am personally responsible for payment of all fees applicable to my treatment by TUMG physicians at the hospital or clinic, including copayments, deductibles, and fees for non-covered services, irrespective of other insurance coverage or other parties' responsibility to me for such fees. If unpaid balances are overdue and are referred for collection, I agree to pay the attorney's fees, court costs, and/or collection agency fees associated with collection. **INITIAL** _____

RELEASE OF INFORMATION: I authorize TUMG and/or its physicians and other clinicians to disclose all or part of my medical or billing records to any insurance carrier or persons employed by such carrier for the purpose of collecting insurance benefits and auditing claims, so long as I am listed on this account as having coverage with such carrier. This authorization includes release of information to group health plans for group insurance coverage, workman's compensation carriers, and welfare agencies, if applicable to my claim for treatment. I hereby indemnify and release TUMG and its physicians and clinicians from any and all responsibility relative to the release of such information. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records: decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. **INITIAL** _____

RX ELIGIBILITY CONSENT: By signing this consent form you are agreeing that TUMG can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors. I hereby provide informed consent to TUMG to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction. **INITIAL _____**

CONSENT FOR TELEMEDICINE SERVICES: I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider. I acknowledge that I have been notified of my right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may revoke my consent to telemedicine services orally or in writing. As long as this consent is in force (has not been revoked) TUMG may provide health care services to me via telemedicine without the need for me to sign another consent. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. I understand that as an existing patient of TUMG my health information will be used and disclosed in accordance with TUMG's Notice of Privacy Practices, a copy of which may be requested at any time. I understand that I can obtain copies of my medical records by contacting my provider's office. I understand that in the event of a technology or equipment failure I should call my providers office to receive further instructions. I understand that telemedicine is not used to provide emergency care and such emergency care should be sought by calling 911. **INITIAL _____**

CONSENT FOR TREATMENT: I, THE PATIENT LISTED BELOW OR SOMEONE WITH LEGAL CAPACITY TO MAKE HEALTHCARE DECISION FOR THE PATIENT, KNOWING THAT (I AM/HE OR SHE IS) SUFFERING FROM A CONDITION REQUIRING DIAGNOSIS AND/OR MEDICAL OR SURGICAL TREATMENT, DO HEREBY VOLUNTARILY CONSENT TO SUCH DIAGNOSTIC PROCEDURES AND HOSPITAL, MEDICAL, AND SURGICAL CARE AS NECESSARY IN THE JUDGMENT OF PHYSICIAN(S) IN CHARGE. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE ME AS TO THE RESULTS OF EXAMINATION OR TREATMENT. I HEREBY AUTHORIZE TUMG TO RETAIN OR DISPOSE OF ANY SPECIMENS OR TISSUES TAKEN FROM MY BODY DURING MY TREATMENT, AND TO USE SUCH SPECIMENS OR TISSUES FOR SCIENTIFIC, EDUCATIONAL, OR RESEARCH PURPOSES, TO THE EXTENT THAT SUCH SPECIMENS AND TISSUES ARE NOT KEPT AT TULANE UNIVERSITY HOSPITAL AND CLINIC. **INITIAL** _____

REFUSAL OF CONSENT FOR TREATMENT. I, the patient listed below or someone with legal capacity to make healthcare decision for the patient, refuse to consent to treatment. I have been advised of the consequences and risks of such refusal, and hereby release the physicians, clinicians, and TUMG from liability for injuries arising from such refusal. ***(ONLY COMPLETE THIS SECTION IF YOU DO NOT CONSENT TO MEDICAL TREATMENT)***

LIST PROCEDURE: _____ PATIENT SIGNATURE: _____

_____	_____	_____
PATIENT NAME	**DATE OF BIRTH**	**RELATIONSHIP TO PATIENT**
_____	_____	_____
SIGNATURE (PATIENT OR PERSON AUTHORIZED TO CONSENT)	**DATE AND TIME**	**WITNESS**

Tulane DOCTORS
Healing People.
Defining Medicine.

Informed Consent for Telemedicine Services

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider.

I acknowledge that I have been notified of my right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may revoke my consent to telemedicine services orally or in writing. As long as this consent is in force (has not been revoked) Tulane University Medical Group may provide health care services to me via telemedicine without the need for me to sign another consent.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. I understand that as an existing patient of Tulane University Medical Group my health information will be used and disclosed in accordance with Tulane University Medical Group's Notice of Privacy Practices, a copy of which may be requested at any time. I understand that I can obtain copies of my medical records by contacting my provider's office. The clinic staff will release my records after they have received written authorization permitting the release of my medical records to my designated recipient.

I understand that in the event of a technology or equipment failure I should call my providers office to receive further instructions. I understand that telemedicine is not used to provide emergency care and such emergency care should be sought by calling 911.

By checking the box below, you are acknowledging the above information and are consenting to receiving telemedicine services from Tulane University Medical Group and its participating providers.

I consent to the terms listed above

☐

Patient Signature or Check Mark

Date and time stamp Print Patient Name Medical Record Number

Approved March 2020
Reviewed March 2020