myMemorialCare

MemorialCare℠
Miller Children's & Women's
Hospital Long Beach

Outpatient Specialty Centers
2801 Atlantic Avenue, Long Beach, CA 90806

Child Proxy Form
Access to Minor's myChart Record

To sign up for access to your child's myChart record, please complete both pages of this Child Proxy Form Completing this form will establish a myChart record for you and for your child(ren). Please note that your child(ren)'s chart will be accessed through your myChart record.

Parent/Guardian Information *: (All sections required - please print clearly)

Name (last, first, middle initial): _____
Social Security Number: _____ Date of Birth: _____
Street Address: _____ City: _____ State: ____ Zip: _____
Email Address: _____ Phone Number: _____
Do you (parent/legal guardian) have an active MyChart account with MemorialCare ? ___Yes ____ No ___ Don't Know

*** Legal Guardian of Minor must attach a copy of the Court Order Appointing Letters of Guardianship verifying the Proxy's status as permanent legal guardian of the patient.**

Please note the following age range limitations for myChart. These age range limitations do not affect any legal right you have to access your child(ren)'s record by other means. To request a paper copy of your child(ren)'s record, contact your child(ren)'s health care provider.

- If a child is **age 0-11:** You will be granted full access to the child's myChart record.
- If a child is **age 12-17:** You will be granted partial access to the child's myChart record. (e.g., appointment scheduling, allergies, immunizations)
- Once a child reaches **age 18,** you will no longer have access to the child's myChart record.

Please provide the following information for each child: (All fields are required).

A. Name *(last, first, middle initial)*: _____
Social Security Number: _____ Date of Birth: _____

B. Name *(last, first, middle initial)*: _____
Social Security Number: _____ Date of Birth: _____

C. Name *(last, first, middle initial)*: _____
Social Security Number: _____ Date of Birth: _____

D. Name *(last, first, middle initial)*: _____
Social Security Number: _____ Date of Birth: _____

➢ **Please remember to complete page 2 of this form.**

myChart Terms and Agreement

By signing below, I understand and agree that:

- myChart is intended as a secure online source of confidential medical information. If I share my myChart ID and password with another person, that person may be able to view my or my child(ren)'s health information, and health information about someone who has authorized me as a myChart proxy;
- It is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way;
- myChart contains selected, limited medical information from a patient's medical record and that myChart does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested from the patient's health care provider;
- My activities within myChart may be tracked by computer audit and that entries I make may become part of the medical record;
- Access to myChart is provided by Memorialcare Health Systems ("MemorialCare") as a convenience to its patients and that Memorialcare has the right to deactivate access to myChart at any time for any reason;
- Use of myChart is voluntary and I am not required to use myChart or to authorize a myChart proxy;
- If my legal relationship with one of the children listed changes, I must inform the health care team immediately by phone or by written communication;
- MemorialCare and/or its subsidiaries and affiliated providers reserve the right to revoke proxy access at any time, for any reason;
- I will (a) send communications on behalf of my child(ren) from that child's record, (b) receive responses in that child's record, and (c) receive email alerts to the email address entered in the email field when creating my MyChart login;
- **myChart should never be used for urgent matters.** The anticipated turnaround time for response to electronic messages is 2 business days. Therefore, for all urgent medical matters, I will contact the physician's office by phone, go to an emergency room, or dial 911.

▶ _____/_____/_____

Signature of Parent/Guardian **Relationship to Patient** **Date (Required)**

▶ _____/_____/_____

Name & Signature of Witness (Office use only) **Practice** **Date (Required)**

Miller Children's & Women's Hospital Long Beach

MemorialCare Health System

Outpatient Specialty Centers

Reporting Patient Safety or Quality of Care Concerns

To Our Patients and Families,

The MemorialCare Health System takes patient safety very seriously and actively participates in several national initiatives to reduce risk to our patients.

Below are a few ways for you to address safety or quality concerns:

- Contact the Outpatient Specialty Center at (562) 933-8000 and ask for a Manager.
- Contact Customer Service at (562) 933-9315.
- If you have contacted these numbers and still feel an issue remains, you may notify the Joint Commission at (800) 994-6610 to report your concern for safety or quality of care without repercussion or disciplinary action from the hospital.

We encourage our staff and physicians to report any unusual occurrences by notifying their supervisor or the Hospital Risk Manager.
Staff may also report issues by calling the Patient Safety Hotline at BESAFE (562) 933-2500 or the MHS Ethics Hotline at (562) 933-9044.

By signing below, I agree that I have read and received a copy of **"Reporting Patient Safety or Quality of Care Concerns"** and **"Patient Safety Starts With You".**

Patient's Name: (Printed) _____ Date: _____

Signature: _____ Relationship to Patient: (If minor) _____

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MemorialCare™
Miller Children's & Women's
Hospital Long Beach

Outpatient Specialty Centers

Patient Agreement

To Our Patients and Families,

To ensure you/your child fully benefit from the medical care and treatment planned by your physician and healthcare team, your participation in following our policies is necessary. With your active participation, we are able to provide the best possible care for you/your child.

1. **Arrive on time for scheduled appointments**
   - If you arrive late your appointment may need to be cancelled and rescheduled.
   - Call 48 hours in advance if you must reschedule. This allows us to schedule another patient waiting for an appointment.
   - If you call less than 24 hours before your appointment it will be considered a missed appointment.
   - You/your child will be removed from the Outpatient Specialty Center and referred back to your Primary Care Physician if 3 appointments are missed in a 12 month period.

2. **Arrive Prepared**
   - Bring a photo ID and current insurance card.
   - Bring a list, pictures of or the actual bottles of your current medications (prescription and over-the-counter).
   - Bring a list of questions, concerns or information you have for your healthcare team.
   - Bring an updated list of other healthcare providers involved in your care (if applicable).

3. **Complete ordered tests and procedures prior to your appointment.**
   If not completed please call at least 48 hours prior to your appointment.

4. **Mutual respect is important.**
   All patient/family and staff interactions are expected to be respectful and courteous.

By signing below, I agree that I have read and received a copy of this agreement.

Patient's Name: (Printed) _____ **Date:** _____

Signature: _____ **Relationship to Patient: (If minor)** _____

MemorialCare™

CONDITIONS OF ADMISSION

- ☐ Long Beach Medical Center
- ☐ Miller Children's & Women's Hospital Long Beach
- ☐ Orange Coast Medical Center
- ☐ Saddleback Medical Center

1. **ARBITRATION:** I understand that any dispute arising out of my hospital or outpatient visit, hospital admission, or Conditions of Admission (COA) agreement will be determined exclusively by submission to arbitration as provided by California law (and as agreed below) on an individual-only basis and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings.

   I also understand that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Such arbitration shall be in accordance with California law including, but not limited to, the provisions of the medical injury compensation reform act. This arbitration agreement shall apply to any and all such disputes or claims arising out of medical or hospital care, treatment or services in connection with this hospitalization against hospital or its employees and any physician, surgeon, dentist, oral surgeon or podiatrist agreeing in writing to be bound by this provision, unless patient or undersigned initials below or unless rescinded by written notice within 30 days of signature.

   Demand for arbitration will be communicated in writing to all parties. Each party will select an arbitrator within 90 days of the written demand for arbitration and a third (neutral) arbitrator will be selected by the arbitrators appointed by the parties within 90 days thereafter. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

   An agreement to arbitrate shall not be a precondition to the furnishing of services under this COA.

   I have read and understand the Arbitration provision and agree / disagree (circle one) with its terms and conditions. Initials: X_____

2. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES:** I consent to the procedures which may be performed during this hospitalization or outpatient visit, which may include but are not limited to, laboratory, x-rays, mammography, medical or surgical services, telehealth services or anesthesia rendered under the general or special instructions of my physician, and screening tests required by law.

3. **HOSPITAL AND NURSING CARE:** I understand that I am under the care and supervision of my attending physician, and the hospital and its nursing staff carry out the instructions of such physician. I further understand that the hospital provides only general duty nursing care and care ordered by my physician(s), and that the hospital is not responsible for failure to provide a private duty nurse. I hereby release the hospital from any and all liability arising from the fact that the hospital does not provide this additional care.

4. **LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN:** I understand that (i) all physicians and surgeons furnishing services to me, including radiologists, pathologists, anesthesiologists, neonatologists, intensive care specialists, emergency department physicians, and other hospital-based physicians, are independent contractors and are **not** employees or agents of the hospital, and accordingly that (ii) fees for physician services are billed separately and independently of hospital charges, which means I will receive more than one bill for services.

   I have read and understand the Legal Relationship Between Hospital and Physician provision and agree to its terms and conditions. Initials: X_____

5. **PERSONAL PROPERTY AND VALUABLES:** I have been encouraged to leave my personal valuables at home. I understand that the hospital is not responsible for my personal property, valuables or belongings and I assume the risk of loss of, or damage to, my personal property, valuables or belongings not placed in the hospital's safe. I understand the potential liability for loss of any of my personal property, valuables or belongings placed in the hospital's safe for safekeeping may be limited by statute to a maximum of five hundred dollars ($500.00).

   I have read and understand the Personal Property and Valuables provision and agree to its terms and conditions. Initials: X_____

A copy of this document is to be delivered to the patient and any other person who signs this document.

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6. **CONSENT TO PHOTOGRAPH:** I consent to be photographed or videotaped while receiving treatment for purposes of my diagnosis, treatment, or the hospital's operations, including peer review and education or training programs. I understand that photography for other purposes (e.g. marketing or public relations) requires separate consent.

7. **PARTICIPATION IN MEDICAL EDUCATION AND CLINICAL TRAINING PROGRAM:** I understand that this hospital participates in teaching programs and that, unless I notify the hospital to the contrary in writing, I consent to receive treatment from residents, fellows, or students, all of whom are under appropriate supervision as required by their medical education and clinical training programs.

8. **PARTICIPATION IN HEALTH INFORMATION EXCHANGE (HIE):** I understand that this hospital may participate in a local, regional or national Health Information Exchange (HIE) including, but not limited to, the National Health Information Network (NHIN). This hospital's participation in a HIE is intended to facilitate access to and retrieval of clinical data as part of the hospital's ongoing effort to provide safer and more timely, efficient, effective, and patient-centered care. HIE may also be useful to public health authorities to assist in analyses of the health of the population. Personal health information that currently by law requires an additional signed authorization for release WILL NOT be transmitted to a HIE without my consent, or as otherwise mandated by law or regulatory requirement. For more detailed information regarding HIE, please refer to our Joint Notice of Privacy Practice or the MemorialCare Chief Compliance/Privacy Officer at (714) 377-3218.

9. **PATIENT RIGHTS AND RESPONSIBILITIES:** I understand that I have rights and responsibilities under state and federal law and that the hospital will provide assistance, including an interpreter, if I need help in order to understand these rights and responsibilities.

10. **IRREVOCABLE ASSIGNMENT OF ALL RIGHTS AND BENEFITS:** In exchange for, and in connection with, any and all of the services provided to me ("Services") by the hospital, whether I sign as patient or agent, I irrevocably assign to the hospital all of my rights, benefits, privileges, protections, claims and any other interests of any kind whatsoever, without limitation, including direct payment to the hospital for the Services, appeal rights, rights to fiduciary duties, rights to sue, rights to payment and rights to penalties or interest (collectively "Rights") that I had, have or may have in the future pursuant to, or in connection with, any insurance plan, health benefit plan, trust fund or any other source of payment, insurance, indemnity or health or medical coverage of any kind (collectively "Health Coverage"), such that I am hereby transferring all and retaining none of these Rights under any Health Coverage to which I am now, previously or may be entitled to in the future. To the same extent as authorized under this irrevocable assignment of Rights, I also authorize assignment of payment to physician(s) for medical treatment and services rendered during my hospitalization or outpatient care.

    I hereby agree to personally cooperate with, and take all steps necessary, required or reasonably requested by any Health Coverage, to effectuate, perfect, confirm or validate my assignment and/or my authorization of the hospital as my authorized representative.

    I understand that I am financially responsible for charges not covered by this assignment or for charges which have not been paid by the insurance company within forty-five (45) days after the billing date.

11. **FINANCIAL AGREEMENT:** I agree to promptly pay all hospital bills in accordance with the rates listed in the hospital's current charge description master, and with the regular terms and standards of the hospital, including its charity care and discount payment policies. I understand that a balance unpaid more than thirty (30) days after presentation of the discharge bill or as mutually agreed by third party contract shall be considered delinquent. If my account is referred to an attorney for collection, I shall pay reasonable attorney's fees and collection expenses. I acknowledge that all delinquent accounts shall bear interest at the legal rate, unless prohibited by law.

12. **HEALTH PLAN OBLIGATION:** I have been informed that the hospital maintains a list of health plans with which it contracts, that the list of such plans is available upon request from the Financial Office, and that the hospital has no contract, expressed or implied, with any plan that does not appear on the list. It is my responsibility to determine if physicians providing services to me contract with my health plan, if any. I agree to pay the full charges of all Services rendered to me by the hospital if I belong to a plan that does not appear on the above mentioned list, or if the Services provided are not covered by my plan. All physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, will bill separately for their services.

13. **MATERNITY PATIENTS:** If I deliver an infant(s) while a patient of this hospital, I agree that this COA applies to the infant(s).

A copy of this document is to be delivered to the patient and any other person who signs this document.

14. **COMMUNICATIONS:** I authorize the hospital, its agents, and independent contractors affiliated with the hospital's medical staff to use any United Stated Postal Service mailing address, use any e-mail address, contact me by telephone via either landline and/or wireless line (by live agent or prerecorded predictive auto-dialer) and wireless free-to-end user text messaging for the purpose of sending me discharge instructions and billing updates/notices/bad debt collection information.

15. **ENFORCEABILITY:** If any provision of this COA is finally determined by a court to be unenforceable, the remainder of this COA shall remain in full force and effect. This hospital COA shall bind the parties hereto, including newborns, and the heirs, representatives, executors, administrators, successors, and assigns of such parties and newborns.

I certify that I have read and understand the foregoing and received a copy thereof. I am the patient, the patient's legal representative, or am otherwise authorized by the patient to sign the above, and I accept its terms and conditions.

NOTICE: BY SIGNING THIS COA YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL UNLESS YOU HAVE DECLINED IN ARTICLE 1 OF THIS CONTRACT.

X _____ _____ _____
Patient / Parent / Guardian / Conservator Date Time

_____
(Relationship if Signed by other than Patient)

_____
Name of Hospital's Duly Authorized Representative (Please Print)

_____ _____ _____
Representative Signature Date Time

Interpreter's Verification: I declare that I have read to the patient, and/or if appropriate his/her representative, the entire contents of this document in the _____ language, which the patient had requested to be used.

_____
Name of Interpreter (Please Print)

_____ _____ _____
Interpreter Signature Date Time

ACKNOWLEDGEMENT OF RECEIPT

Patient Rights	☐ Copy Provided	☐ Copy Declined		Initial Here: X_____
Mammography Information	☐ Copy Provided	☐ Copy Declined	☐ N/A	Initial Here: X_____
Car Seat Information	☐ Copy Provided	☐ Copy Declined	☐ N/A	Initial Here: X_____

"Internal Use Only"

☐ Series Account Expiration/End Date: _____

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