Pediatric Services

Patient Name:_____

Patient Date of Birth: _____

General Consent

Consent to Treat

I consent to and authorize the physicians, nurses and other healthcare providers at Pediatric Services, PA to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

Pediatric Services, PA is a teaching clinic. In addition to my clinician and other medical support staff, I may receive care from people who are in training. They are supervised by licensed health care providers.

Assignment of Benefits/Payment for Services

I authorize payment of any and all benefits to Pediatric Services, PA. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with Pediatric Services, PA to get payment for my care. This includes clearing up any disputes about charges. If I am eligible for payment from more than one type of coverage, Pediatric Services, PA will return any extra payments to the payer. If I have an unpaid bill at Pediatric Services, PA, any refunds due to me will be put on my unpaid bill. If there is money left over after my bill is paid, I will get a refund from Pediatric Services, PA.

Release of Information for Treatment, Payment and Health Care Operations

I consent to and authorize Pediatric Services, PA to use and disclose my protected health information for **treatment**, **payment** and **healthcare operation purposes**, including care coordination and quality assessment and improvement activities. Releases for these purposes may be made to consultants who are being advised or consulted in connection with my treatment, insurance companies, health plans, e-prescribing services, record locator services, payer network organizations, including clinically integrated networks and/or accountable care organizations in which my provider participates, and other healthcare providers involved in my care and treatment, including any business associates of these organizations. Pediatric Services, PA may take photos and/or videos during your medical care and these photos and or videos may be used for care, quality assessment and improvement and medical education. Additionally, I consent to and authorize my insurance company to share any of my protected health information for the purposes stated above to Pediatric Services, PA and/or a clinically integrated network or accountable care organization in which Pediatric Services, PA participates.

Patient Rights and Privacy Practices

You and your family's rights and our privacy practices are posted in main areas within Pediatric Services, PA. Your signature acknowledges receipt of our Patient Rights and Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider or Pediatric Services, PA Privacy Officer.

Other Third-Party Individuals Authorized to Consent to Treatment

In addition to the legal guardians of the patient, the following persons are authorized to consent to the recommended medical care for my child (e.g., grandparent, daycare provider, etc.):

Parent Consent

I allow the physicians and nurses at Pediatric Services, PA to speak with my parent or parents listed below regarding my medical care. I allow access to all medical records and Pediatric Services, PA patient portal.

Name:	**Relationship to Patient:**
1._____	_____
2._____	_____

Mobile Phone Consent

Yes, Pediatric Services, PA may call my provided mobile phone number about the care, treatment, services and accounts using pre-recorded messages, automatic telephone dialing systems and/or text messages. Standard text message and minute usage rates may apply. I am aware information in a voice or text message may not be secure and that providing this consent is not a condition of receiving treatment.

My signature here means I have read this information and understand it. This consent is valid for one year from the date of signature and can only be revoked in writing (paper or email).

Print Patient Name:_____

Patient/Parent/Guardian Signature: _____ **Date:**_____

Name of Interpreter (if used):_____

Patient Email Address:_____

Telephone consent obtained by (Name/Date/Title): _____