General Consent

Patient Name: ______________________________
Date of birth:_______________________________

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.

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. 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

I consent to and authorize Pediatric Services, PA to use and disclose my protected health information for: **Treatment, Payment**, **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. 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 Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please request a copy from the front desk.

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.

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. The consent to treat is valid for one year from the date of signature. All other authorizations contained in this consent are valid until revoked in writing.

Print Patient Name:_____________________________________ **Date:**_____________________________

Patient Signature:____