Kidzcare Pediatrics- General Consent Form

The following will be in effect unless specifically revoked in writing, updated, or a change in policy.

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ **Consent to Treatment**: I do hereby voluntarily request care at Kidzcare Pediatrics for my child and or the *Initial*  members of my household that I designate. Care can be (but not limited to): in person, telephonic, telemedicine, or vial portal. I hereby authorize and grant permission and consent for all physicians, physician assistants, nurse practitioners, and clinical staff employed by Kidzcare Pediatrics to use such diagnostic and treatment procedures they deem necessary for proper medical management of myself/my child and to said members of my household. The clinic, its medical staff, and employees are hereby released from any liability for the results of such procedures.

\_\_\_\_\_\_\_ **Prescription Access:** I consent to give Kidzcare Pediatrics access to my medication/prescription history to assist *Initial* in proper medical management.

\_\_\_\_\_\_\_ **Financial Agreement:** I understand that my insurance is a contract between myself and the insurance company, *Initial* not between the insurance company and the doctor. I understand that any balance remaining after insurance pays or denies payment, is my responsibility to pay. I hereby authorize and request my insurance company to pay directly to Kidzcare Pediatrics the amount due in my pending claim.

\_\_\_\_\_\_\_ **Co-payments:** If insurance requires co-payment for office visits, you will be required to pay this at the time of *Initial* check-in.

\_\_\_\_\_\_\_ **Self Pay Patients (No Insurance Coverage):** Patients without any valid insurance coverage will be required to pay *Initial* for any charges at time of service. If you are unable to pay the balance at the time of the visit, a payment plan may be arranged by the Billing Office.

\_\_\_\_\_\_\_ **Non-Covered Services:** I agree to be financially responsible for any charges associated with services which are *Initial* not reasonably necessary for the diagnosis or treatment of my child or said members of my household, but are provided for the convenience of the patient, his/her family, or physician regardless of payor source.

\_\_\_\_\_\_\_ **Coding for your Services:** Many insurance companies have restrictions on the type of services that are covered *Initial* by their policies. It is the responsibility of the parent/patient to know the limitations of your insurance coverage. For example, preventative services may be excluded or limited to only 1 preventative visit in a 12- month period; or problem related visits may be subject to a deductible, etc. Government regulations dictate that all healthcare providers must submit claims that accurately reflect the services that are provided and uphold the highest ethical degree of accuracy. We ask that you do not ask our staff to alter services in a manner to enhance reimbursement by your insurance company. Based on this, in the event you are seeing a Kidzcare Pediatric provider for preventative services, but at the same time encounter or address additional problem-related issues, Kidzcare Pediatrics may be required to charge for these additional services. This occurs when additional issues meet certain criteria that are considered above and beyond the scope of the preventative visit. This is necessary for Kidzcare Pediatrics to meet established coding guidelines.

\_\_\_\_\_\_\_ **Smoke Free Policy:** I have been informed of Kidzcare Pediatrics smoke free policy and understand smoking and *Initial* the use of tobacco products (including e-cigarette/vapes) is only allowed in designated areas located outside of the building. No smoking of any kind is allowed inside the building.

\_\_\_\_\_\_\_ **Treatment of a Minor:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has permission to bring my *Initial* child (who is under the age of 18) to Kidzcare Pediatrics for treatment and make necessary decisions.

\_\_\_\_\_\_\_ **Failure to Keep Appointments:** Kidzcare Pediatrics maintains a policy that the practice can discharge a patient *Initial* who routinely fails to keep appointments without canceling. If you cannot keep your appointment for any reason, please call our office ahead of the appointment day, so that the appointment can be made available to someone else who needs our services.

\_\_\_\_\_\_\_ **Prescription Refills:** We ask that you call our office for all refill requests. Some prescription refills cannot be *Initial* called in and require an appointment. Please allow your pharmacy one business day to receive the prescription before checking with our pharmacy to see if it was filled.

\_\_\_\_\_\_\_ **Notice of Privacy Practices:** Kidzcare Pediatrics Notice of Privacy Practices has been provided to me and a copy *Initial* is available in the lobby. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment. It also describes my rights and the duties of Kidzcare Pediatrics with respect to my protected health information.

I consent to the use or disclosure of my protected health information by Kidzcare Pediatrics for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills, or to conduct healthcare operations of Kidzcare Pediatrics. I understand that I have the right to request restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Kidzcare Pediatrics is not required to agree with the restrictions that I may request. However, if Kidzcare Pediatrics agrees to a restriction that I request, the restriction is binding on Kidzcare Pediatrics. My protected health information means health information including my demographic information, collected from me, and created or received by my physicians, information related to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me. I have the right to revoke my consent in writing at any time except to the extent that Kidzcare Pediatrics has acted in reliance of the consent. Kidzcare Pediatrics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Practices policy by calling the office and requesting a copy be sent in the mail or asking for one at the time of my next appointment.

Please list the persons, if any, that Kidzcare Pediatrics may release information to on your general medical condition,

 treatment, and diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the persons, if any, who Kidzcare Pediatrics may inform about your medical condition ONLY IN AN EMERGENCY

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Telephone number where you wish to receive calls about your appointment, lab and/or x-ray results, or other healthcare

information, if other than your home number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

This office may use a PIN number as a way to confirm consent to speak on the phone, what would you like your PIN

number to be?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By affixing signature below, I agree to the above, including Notice of Privacy Practices and Consent to Treatment

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_