Patient Consent/Representative Form Pediatric

Notice of Privacy Practices Acknowledgement

By signing this Consent Form, you give ConnextCare permission to treat your minor child and use and disclose protected health information about them for treatment, payment, healthcare and/or dental care and treatment. This excludes only restrictions specified below to which we have agreed. *Protected health information* is individually identifiable information we create or receive, including demographic information, relating to your physical/dental or mental health, for the provision of healthcare services to the patient, and to the collection of payment for providing healthcare/dental services to the patient.

By signing this Consent Form you are giving ConnextCare permission to schedule both in-office and telehealth appointments. A telehealth appointment may be conducted via telephone, Greenway, other HIPAA compliant platforms. In-office and telehealth appointments will be billed accordingly and in adherence to state and federal requirements.

Our Notice of Privacy Practices provides information about how ConnextCare may use and disclose protected health information. You have the right to receive a copy of our Notice of Privacy Practices and Patient Bill of Rights before signing this Consent Form, they have been sent to you electronically. By signing this consent form, you acknowledge that you have received/been made aware of our ***Notice of Privacy Practices, Non-Discrimination Notice,*** and the ***Patient Bill of Rights***. You can also review them on the ConnextCare website or request a hard copy any time at the front desk.

If you do not sign this Consent Form, ConnextCare has the right to refuse to provide treatment unless a licensed healthcare professional has determined that your child requires emergency treatment, it is determined that care is in the child's best interest and we are required by law to treat you. ConnextCare is required to document any circumstances in which we do not obtain parental consent and carry out treatment. Please be aware that, per federal and state law, **Adolescent patients** have the right to consent to reproductive care and certain confidential services independently and parents/guardians may not have access to this information without the patient's consent.

You have the right to request that ConnextCare restrict how protected health information is used or disclosed for treatment, payment, healthcare or dental operations. ConnextCare is not required to agree to any restrictions, but if we do, we are bound by our agreement. If you wish to make a restriction, please request a copy of our Form to Request Restriction (CC 003.02). You have the right to revoke this consent at any time except where we have already made disclosures in reliance on your prior consent. A signed ***Authorization for Release of Medical Information*** must be completed to share information.

You understand that photographs, videotapes, digital, or other images may be recorded to document care, and consent to this. Images that identify you will be released and/or used outside the institution only upon written authorization from you or your legal representative.

☐ **I consent to billing and treatment at ConnextCare**

☐ **I received a copy of my Patient Rights and the Notice of Privacy Practices and the Non-Discrimination Notice**

Patient's Name: _____ Patient's DOB: _____

Legal Parent/Guardian #1: _____Relationship: _____

Phone number /Contact Information:_____

Legal Parent/Guardian #2:_____Relationship: _____

Phone number /Contact Information:_____

Designated Representative Pediatric Patients

In the case of an incident where I am not able to bring my child for his/her appointment, or if emergency treatment is required, I understand that any of the persons listed on this form will be allowed to arrange and seek treatment for my child. **I understand that it is my responsibility to notify ConnextCare of any changes to the information provided on this form and to provide the office with the most up-to-date custody/guardianship paperwork for my child.** I authorize the below individuals to consent for treatment in the absence of the parents/guardians previously listed:

Adult Authorized to give consent:_____Relationship: _____

Phone number /Contact Information:_____

Adult Authorized to give consent:_____Relationship: _____

Phone number /Contact Information:_____

Parent/Guardian Signature: _____ Date:_____