Chillicothe Pediatrics
General Consent Agreement

Consent for Medical Treatment: ☐ **Accept** ☐ **Decline** **_____ initial**

I consent to let the clinical providers and employees of Chillicothe Pediatrics (the practice) do all things that may be needed to diagnose, treat and care for the needs of the patient referenced below to include any necessary examination, immunizations, medical diagnosis, surgery, treatment and/or hospital care to be rendered to the minor child named below under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the State of Ohio.

I understand that the practice is not responsible for personal belongings lost during my visit.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me about the result of my examination or treatment.

Patient Rights and Responsibilities (see attachment): ☐ **Accept** ☐ **Decline** **_____ initial**

I understand I have the right to take part in decisions about the health care and plan for treatment. I have received a copy of the Patient Rights and Responsibilities and my questions have been answered.

Consent to Release Medical Information: ☐ **Accept** ☐ **Decline** **_____ initial**

I consent to let the practice share/release/exchange information such as clinical research, physical, mental, drug alcohol, HIV or AIDS (including information that state and federal law and accreditation agencies require) to/with my doctors, health care provider, and/or to any insurance company or organization that helps pay my bill. The practice may also give information to any welfare organization to which I have applied or may apply for aid.

Assignment of Insurance Benefits: ☐ **Accept** ☐ **Decline** **_____ initial**

I assign to the practice, my physician and other healthcare professionals involved in the patient's care, all my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available to pay the practice for medical services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

Financial Responsibility: ☐ **Accept** ☐ **Decline** **_____ initial**

I (or my guarantor, if appropriate) will pay all bills for care including bills that insurance benefits do not pay. This includes bills from the practice, physicians or any other entities that provided services during my care. I certify that the information I have given the practice regarding my family size and income is accurate to the best of my knowledge.

Practice Price Disclosure: ☐ **Accept** ☐ **Decline** **_____ initial**

I have a right to see a list of prices for common medical procedures.

Removal from the practice: ☐ **Accept** ☐ **Decline** **_____ initial**

If I decide to stop medical care against the advice of doctors, I understand that the practice and doctor(s) are not responsible for any bad result after I leave.

Acknowledgment of Receipt of Notice of Privacy Practices: ☐ **Accept** ☐ **Decline** **_____ initial**

I hereby acknowledge that I was offered a copy of the Notice of Privacy Practices which sets forth the ways in which protected health information may be used or disclosed by the practice and outlines my rights with respect to such information.

Attachments: Patient Rights and Responsibilities
Notice of Privacy Practices

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Consent for Automated Calls and Texts: ☐ **Accept** ☐ **Decline** **_____ initial**

I expressly authorize the practice, its affiliated entities, and third party service providers to call or text me at any wireless phone number associated with my account(s), including any phone number that may result in charges to me, whether provided in the past, present, or future. I agree that methods of contact may include use of pre-recorded or artificial voices or an automatic dialing system. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services from the practice.

Patient Portal Access: ☐ **Accept** ☐ **Decline** **_____ initial**

The practice offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks, we need to impose some conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass- phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

BY SIGNING, I CONFIRM THAT I HAVE LEGAL ABILITY TO CONSENT FOR THE TREATMENT.

Patient Name(s)_____

Signed_____ Signed_____

PATIENT, IF 18 YEARS OR OLDER DATE TIME PARENT/GUARDIAN, IF PATIENT IS LESS THAN 18 YEARS DATE TIME

Signed_____ _____

WITNESS DATE TIME PRINT NAME OF PARENT/GUARDIAN

_____(_____)_____

STREET ADDRESS CITY STATE ZIP CODE AREA CODE PHONE NUMBER

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Notice of Privacy Practices