HOME CARE PEDIATRICS CONSENT FORM

CONSENT FOR MEDICAL TREATMENT: I voluntarily consent for my child to receive evaluation, care, and treatment from providers (including any physician, physician assistant or nurse practitioner) working for Home Care Pediatrics. I understand such services may include examination, medical and minor surgical treatment, x-ray, laboratory, immunizations and other medical services performed or prescribed. Further, I understand that should any Home Care Pediatrics provider or other person(s) be exposed or report an exposure to the blood or body fluids of my child, my child's blood may be tested for blood borne infections including Hepatitis Band C. I am aware that the practice of medicine is not an exact science, and acknowledge that no guarantee or promises have been made as to the result of treatment or examination.

I understand that this consent to treatment will be valid and remain in effect unless revoked by me in writing with such written notice provided to Home Care Pediatrics.

FINANCIAL AGREEMENT: **I acknowledge that Home Care Pediatrics does not accept health insurance.** I understand and agree that I am financially responsible to Home Care Pediatrics for all products and services provided to me. I understand that fees for services are due at the time services are rendered. I understand that based on my child's health visit with Home Care Pediatrics, subsequent evaluation and/or treatment may be needed including referral to an acute care facility to properly treat my child's condition at my expense.

RELEASE OF HEALTH INFORMATION: I authorize Home Care Pediatrics to release any information regarding my child acquired in the course of my examination and treatment to any authorized agent for the purposes of healthcare, treatment, and payment. I authorize the release of medical information to healthcare providers involved in my child's care; to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs. I hereby released Home Care Pediatrics and all of its employees from liability and all claims pertaining to disclosure of this information.

COMMUNICATION CONSENT: I authorize Home Care Pediatrics to communicate with me by phone, email, standard SMS messaging, or telehealth regarding the medical care of my child.

MEDICAL AUTHORIZATION: In addition to myself, I authorize the following individual(s) to make healthcare decisions, receive communication, and be the adult present for healthcare visits for my child.

Name_____ Relationship_____

Name_____ Relationship_____

Notice of Privacy Practices: I acknowledge that I have received Home Care Pediatrics' Notice of Privacy Practices.

INITIAL_____

Patient Name_____DOB_____

_____ _____

Signature of patient or legally responsible party Date

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Relationship to patient (if not signed by patient)