Southdale pediatric associates, ltd.

Consent for Services

Patient Name________________________________ **Date of Birth**_________________

Authorization for Treatment:
I authorize Southdale Pediatric Associates, Ltd. to provide treatment to myself or the above named patient.

Assignment of Benefits/Payment Agreement/Collection Policy:
I authorize payment for any and all benefits to Southdale Pediatric Associates, Ltd. It is my responsibility to provide current insurance information. I am responsible for the payment of any remaining balances that are not covered by my insurance, plus any costs that are incurred by Southdale Pediatric Associates, Ltd., in collecting my account.

Reference Laboratory Services:
Southdale Pediatric Associates, Ltd. utilizes the services of an outside reference laboratory to perform some of the lab tests ordered by its physicians. The **Reference Laboratory** will bill separately for its services.

Notice of Privacy Practices:
Southdale Pediatric Associates, Ltd. has provided me with a copy of their Privacy Practices.

Cancellation of Appointments:
Southdale Pediatric Associates, Ltd. requires a 24 hour notice to cancel any appointment. Future services may be denied if a patient fails to keep scheduled appointments.

Non-Violence Policy:
Southdale Pediatric Associates, Ltd. is committed to providing its employees with a safe, nonviolent workplace and reserves the right to determine whether particular conduct violates this policy or is otherwise inappropriate.

Patient Portal:
In return for access to the Patient portal you agree not to:

- Transmit any electronic information that violates the rights or privacy of any party.
- Use the portal in any way that violates local, state of federal law,
- Transmit any materials that are obscene, defamatory, abusive, slanderous, hatefully or otherwise likely to result in harm to others; or
- Intentionally distribute viruses or other harmful computer codes; or have taken any other action that could compromise the security of our computer system.

___ Yes- I consent to Patient Portal enrollment.
___ No - I am deferring enrollment at this time.

Authorization for Release of Medical Information:
I authorize Southdale Pediatric Associates, Ltd. to use and disclose my protected health information for:

- Treatment
- Payment
- Healthcare Operations, including care coordination and quality improvement activities.
- Research – No patient names or identifying information are ever shared.

Releases may be made to insurance companies, health plans, government programs, e-prescribe databases, payer network organizations, including clinically integrated networks and/or accountable care organizations in which my provider participates as well as other healthcare providers involved in my care and treatment.

In addition, I authorize my insurance company to share my protected health information for the purposes stated above to Southdale Pediatric Associates, Ltd. and/or a clinically integrated network or accountable care organization in which Southdale Pediatric Associates, Ltd. participates. If I do not agree to this, I will initial below:

______My insurance company **MAY NOT RELEASE** any of my protected health information from providers unrelated to Southdale Pediatric Associates, Ltd. for the purposes described above.

By signing this form, I agree that I have read and understand the information included on this form. This consent is valid until revoked in writing.

_________________ ____ ___________________________
Date Signature Patient (if 18 yr.) / Parent / Legal Guardian Relationship to Patient