Consent for Services

Patient Name_____ **Date of Birth**_____

I authorize Southdale Pediatric Associates, Ltd. to **provide treatment** to myself or the above named patient.

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.

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. I am responsible for the payment of any remaining balances that are not covered by my insurance.

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

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.

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.

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, 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.

I authorize Southdale Pediatric Associates, Ltd. to use and disclose my protected health information to:

- Outside Medical Providers:
  - For treatment and continuity of care
- Insurance Companies
  - For claims payments
- Research – No patient names or identifying information are ever shared
- Healthcare Operations:
  - For government programs such as MIIC,
  - For e-prescribe databases such as Surescripts,
  - For Health Information Exchange (HIE)
    - _____ I choose to OPT OUT of the sharing of my protected health information with CommonWell Health Alliance
  - For payer network organizations, including clinically integrated networks and/or accountable care organizations.
    - _____ I choose to OPT OUT of the sharing of my protected health information with Fairview's ACO

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