

# Consent for Services

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

I authorize Southdale Pediatric Associates, Ltd. (Southdale Pediatrics) to **provide treatment** for myself or the above-named patient.

I authorize **payment** for any and all benefits to Southdale Pediatrics. 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 Pediatrics in collecting my account.

Southdale Pediatrics 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 Pediatrics will provide me with a copy of their **Privacy Practices** upon request.

I consent to Southdale Pediatrics sending text (SMS) messages to the mobile number I have provided in my records. No mobile opt-in or text message consent will be shared with third parties or affiliates.

Southdale Pediatrics may use forms of AI to help transcribe notes within the electronic medical record. Southdale Pediatrics may also take photos during your medical care.

Southdale Pediatrics requires a **24 hour notice to cancel any appointment**. Future services may be denied if a patient fails to keep scheduled appointments.

Southdale Pediatrics 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 or federal law or transmit any materials that are obscene, defamatory, abusive, slanderous, or otherwise likely to result in harm to others.

## **Release of Information for Treatment, Payment and Health Care Operations**

I consent to and authorize Southdale Pediatrics to use and disclose my protected health information for treatment, payment and healthcare operation purposes, including care coordination and quality assessment and improvement activities. Releases for these purposes may be made to consultants who are being advised or consulted in connection with my treatment, insurance companies, health plans, e-prescribing services, record locator services, payer network organizations, including clinically integrated networks and/or accountable care organizations in which my provider participates, and other healthcare providers involved in my care and treatment. Additionally, I consent to and authorize my insurance company to share any of my protected health information for the purposes stated above to Southdale Pediatrics and/or a clinically integrated network or accountable care organization in which Southdale Pediatrics participates.

## **Consent for Electronic Health Information Exchange (HIE)**

I consent to Southdale Pediatrics and my providers to electronically obtain and share my/my child's health care information for coordinating my/my child's care and treatment. This consent permits Southdale Pediatrics and its providers to: 1) electronically request and obtain my/my child's health records from other health care providers that have provided care and treatment to me/my child; and 2) make my/my child's Southdale Pediatrics medical records available electronically to other health care providers who provide care to me. These records may include testing, diagnosis, treatment, demographic and registration records created while providing services to me/my child for all medical and health conditions. I understand that sharing health care information is with HIE. If I do not wish to share my records via HIE, I will make an X through this paragraph.

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