

South Lake Pediatrics Consent For Services

Thank you for choosing South Lake Pediatrics

Consent for Treatment

I hereby consent to and authorize the attending physician, certified nurse practitioner or their assistants and designees of South Lake Pediatrics to perform such examinations, treatments, laboratory tests, diagnostic radiological procedure, administration of immunizations and such medications as in his or her medical opinion are necessary or advisable. This consent also includes any other diagnostic procedure. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments, examinations or diagnostic procedures.

Notice of Privacy Practices

In compliance with HIPAA legislation, I have been provided an opportunity to review South Lake Pediatrics Privacy Practices.

Non-Violence Philosophy

South Lake Pediatrics recognizes that it is in the best interest of the community, employees, customers and the organization as a whole, to maintain an environment which is free from violence and harassment. Threats, harassment, aggressive or violent behavior by employees, patients, parents, visitors or others will not be tolerated. South Lake Pediatrics will hold all individuals responsible for the effect their behavior has on the clinic.

Release of Medical Information

In order to assure proper follow-up and continuity of care, I agree that a copy of my South Lake Pediatrics medical information may be released upon request to my physician, a designated referral physician and/or any provider involved in my treatment. I authorize South Lake Pediatrics to mail or fax a copy of medical information to a non-medical facility, such as a day care provider, camp or a school, when I make such a request. I understand that my medical information may be reviewed for quality improvement activities.

Regarding Insurance

I am responsible for providing South Lake Pediatrics with insurance information that is complete and current. I consent to the release of medical or other information necessary to an insurance company or 3rd party payer for purposes of payment as indicated by MN law. I authorize payment of insurance or 3rd party medical benefits to South Lake Pediatrics for services rendered.

Blood Borne Infectious Disease Testing

I understand that while my child is receiving care, the health care worker may accidentally be exposed to my child's blood or other body fluid. If this rare event occurs, I understand that my child's blood will be tested for the presence of blood borne pathogens (hepatitis B, hepatitis C, and human immunodeficiency virus) in accordance with public health policy. These tests are necessary to help protect and counsel the exposed individual. I understand the results of such test will be part of my medical record and will not be released except with my prior authorization or as required or permitted by law.

X-Ray & Reference Laboratory Services

I understand that if my child receives an x-ray as part of his/her diagnosis or treatment, the x-ray will be reviewed by an outside radiologist. I understand that blood and other specimens may be sent to an outside laboratory for testing. I further understand that the radiologist and reference laboratory will bill separately for their services. I consent to South Lake Pediatrics supplying the radiologist and/or the reference lab with my demographic information as necessary for billing purposes.

Cancellation of Appointments

I understand that I must give the clinic a 24 hour notice of any canceled appointments. If I fail to keep my scheduled appointments, I may not receive future services.

Financial Policy

When I visit the clinic for health care, I undertake a personal obligation and responsibility for my account. I am responsible for knowing my insurance benefits. I understand that it is my responsibility to provide South Lake Pediatrics with current and complete information. I have been provided an opportunity to review South Lakes Pediatrics complete Financial Policy on the back of this form. I understand it is also available in the South Lake Pediatrics Patient Handbook, on the back of billing statements and on the South Lake Pediatrics website.

BY CONSENTING TO TREATMENT AND SIGNING THIS FORM, I AM AGREEING TO THESE POLICIES.

Patient Name: _____

Patient Date of Birth: _____

Patient/Parent/Guardian Signature: _____

Date: _____