Partners in Pediatrics Ltd.
Health Care for Children and Adolescents
www.pipstop.com

Patient Name: _____

Patient Birthdate: _____

PIP Account #: _____

PATIENT CONSENT FORM

TO OUR PATIENTS: The law requires that we explain your rights and responsibilities while a patient at Partners in Pediatrics. If you have a complaint or concern about your care, please discuss it first with your care provider. If your concern remains unresolved, you may contact the site manager. Please read and sign the form below. Ask questions if you do not understand it. If you need a language interpreter, we can provide one for you.

- **CONSENT FOR TREATMENT:** I hereby consent to and authorize the attending physicians, referral physicians, or their assistants and designees of Partners in Pediatrics to perform such examinations, treatments, laboratory tests, procedures, and to administer such medications as in his or her opinion are necessary or advisable. This consent also includes all routine diagnostic radiological procedures. My child's personal health information may be used for their treatment.

- **OTHER INDIVIDUALS AUTHORIZED TO CONSENT TO TREATMENT:** In addition to legal guardians of the patient, the following persons are authorized to consent to recommended medical care for my child.
  Name and relationship to patient (grandmother, grandfather, aunt, daycare provider, etc.)
  _____
  _____
  _____

- **INSURANCE/MEDICAID/MEDICARE ASSIGNMENT OF BENEFITS:** I consent to the disclosure of my protected health information for the purpose of payment, treatment, and heath care operations. I request that payment of authorized benefits be made to Partners in Pediatrics on my behalf for any services furnished to me or my child by Partners in Pediatrics. I assign the benefits payable for physician services to the physician or organization furnishing the services. In consideration of clinic visits, I agree to pay Partners in Pediatrics for all charges not covered by any third party payer.

- **BLOOD TESTING:** I understand that while I or my child is a patient of Partners in Pediatrics, a health care worker may accidentally be exposed to blood or bodily fluids. If this unusual event occurs, I understand that my child's blood will be drawn and tested for the presence of infection with HIV (the AIDS virus), or for the presence of Hepatitis B and C. These tests are necessary to help protect and counsel the health care worker. I understand the results of these tests will be kept confidential and will not be released without my prior consent or as required by law.

- **SERVICES OR SUPPLIES:** Partners in Pediatrics may use other companies to help in the evaluation and treatment of your child. If another company performs a service or provides equipment, they will bill your insurance. Partners in Pediatrics cannot answer questions about bills received from other companies.

- **PATIENT'S RIGHT TO PRIVACY:** I acknowledge that I have been made aware of Partners in Pediatrics' privacy practices, which are posted in the reception area. At my request, a written copy of Partners in Pediatrics' privacy brochure will be provided.

Partners in Pediatrics is a teaching clinic. I understand that I may be asked to have a medical student involved in my exam. I also understand that I may decline and that this declination will not affect my care or treatment.

I understand that I have the right to revoke this consent by submitting a written statement at any time, except where Partners in Pediatrics has already made disclosures in reliance on this consent.

Except in an emergency situation, Partners in Pediatrics reserves the right to decline care if this form is not signed.

This consent expires one year from the date of the signature.

_____ _____
Signature of parent/guardian Relationship to patient

_____ _____
Printed name Date