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We the physicians and staff of Caring Pediatric Partners preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients as a matter of policy. This policy ensures that our practice- physician, providers and staff - have the necessary medical and protected health information (PHI) to provide the highest quality medical care possible, while protecting the confidentiality of the PHI of our patients to the highest degree possible.

CONSENT FORM FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Child Name: _____ **DOB:** _____

I hereby give my consent to Caring Pediatric Partners, PC for the purpose of treatment, payment and healthcare operations for the above named child.

I hereby give my consent for the above named child to be treated by Caring Pediatric Partners, PC, in my absence, for emergency care.

I hereby give my consent for medical information pertaining to a diagnosis, be given to other facilities required for further testing and treatment of that diagnosis, with our referral.

I hereby give my consent that the above named child’s vaccine(s) be recorded in MCIR (Michigan Care Improvement Registry).

I hereby give my consent for the information of name, birth date, address, telephone number, insurance, and parent’s information, including social security numbers, and employer to be given out for obtaining payment of services rendered and/or referrals for further treatment.

Our office policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the front office or business manager. If the account is not paid within 90 days of the date of service and no financial arrangement has been made, I will be responsible for any expenses incurred in collecting the account.

I hereby authorize payment of benefits directly to the provider for services rendered to my child. I further authorize Caring Pediatric Partners, PC to release any information required to process insurance claims.

Any information pertaining to HIV/AIDS, Mental Health, or Substance Abuse Treatment will require a specific written authorization for release.

OPTIONAL:

I give my consent for my child’s medical information to be shared with the caregivers listed below:

(List any relatives, daycare providers, nurses, or other’s that may care for your child other than parents or guardians.)

I give Caring Pediatric Partners, PC consent to discuss and disclose any and all health information with the person or persons listed below in our office, or by phone. The parties listed below have my permission to sign and give consent for vaccine administration.

The parties listed below may also pick up prescription orders for controlled substances.

Please list name and date of birth:

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

By signing this notice I am agreeing to the above statements, and have the right to revoke this consent and authorization at any time.

Signature

Relationship

Date

Effective Date: March 01, 2021