Authorizations and Consents

Patient: _____

Date of Birth: _____

Please Initial after each paragraph.

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize All Ages Pediatrics, (AAP), its medical practices and providers including physicians, technicians, nurses, and other qualified personnel, including appropriately supervised students to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures. TREATMENT OF MINOR CHILDREN: I understand minor child patients must be accompanied by a parent or legal guardian. A parent may designate a representative to bring their child for medical care. I understand that charges for services rendered to minor children are the responsibility of the guardian for the child, regardless of who brought the child, or who is court-ordered to be financially responsible. I also understand that, in these consents, where applicable, I, or my, also refer to "my child" where appropriate. _____

PHOTOGRAPHY/VIDEO: I acknowledge that my or my childs photograph may be taken for Chart identification and documentation purposes for my electronic health record and is the property AAP unless I withdraw my consent in writing. I consent to security videos in public areas. I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement. _____

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly by AAPP for providers of service(s) furnished to me and my children. I authorize AAP to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to AAP. I hereby authorize that photocopies of this form are as valid as the original. _____

SELF-PAY PATIENTS: I understand if I do not have active coverage or choose not to utilize my insurance benefits, I am responsible for all charges that occurred at the time of service. The practice maintains a cash pay schedule in these situations. _____

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through AAP medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a AAP billing statement whether it is an interim or final bill. If I fail to make full payment or fail to comply with other payment arrangements made with AAP's approval, I understand that appropriate collection measures may be initiated. ____

RESTRICTED SERVICE: I understand that all account balances must be in good standing prior to receiving additional services and will contact AAP's staff if I am unable to pay your balance. Past Due Accounts of 60 days or longer may be turned over to a third-party for collection, along with collection costs, attorneys' fees and court fees. I also understand I may be discharged from practice for outstanding debt. ADDITIONAL SERVICE CHARGES: Checks may be processed at time of service, if there are insufficient funds available, I understand I will be responsible for providing an alternate payment for the account amount, plus a $35.00 NSF fee. _____

ELECTRONIC HEALTH RECORD: I understand the following: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. AAP has a secure cloud-based electronic medical record that is available to caregivers on a "need to know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained according to relevant governmental and regulatory standards. Patient care summaries are automatically sent to designated AAP and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. AAP and/or the attending physician can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record. _____

I give permission to share my or my child's electronic medical record among my healthcare providers and obtain medication history through a Provider Health Information Exchange (HIE or medical record-sharing). AAP will follow state and federal laws regarding the access by medical providers of any sensitive information, such as behavioral health, substance abuse treatment, sexual abuse, genetic test results, HIV/AIDS status and adoption records. _____

A valid email address is required for labs and communication to be published to your patient portal, it is my responsibility to update the practice of any changes to my e-mail address. I am requesting the ability to access my or my childs medical information through the Center for Primary Care online Patient Portal. _____

ELECTRONIC PRESCRIBING: **I** understand that AAP medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my AAP providers and my pharmacy. I have been informed and understand that AAP providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my CPC providers to see this health information. ____

CONSENT FOR VIRTUAL HEALTH/TELEMEDICINE SERVICES: I hereby consent to engaging in virtual health or telemedicine services, where and when available, as part of my or my childs treatment. I understand that "virtual health" or "telemedicine services" includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location. The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. I understand that the potential benefits of receiving care in this manner include improved access to care and the ability to obtain the expertise of a distant specialist. The potential risks include problems with information transmittal, including but not limited to poor video and data quality experience, or lack of access to my complete medical record by the remote physician. I understand that all information, including images, will be part of my or my childs medical record available to me if requested and with the same restrictions on dissemination. _____

IMMUNIZATION REGISTRY: I understand that AAP participates in the Iowa Immunization Registry Information System (IRIS,) a statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws. I understand that Iowa law does not require consent for AAP to send or fax childhood immunization records to schools, upon request, but that an opt out can be requested. _____

CELL PHONES: I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from AAP, or its assignees can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time. _____

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all AAP medical practices and offices provide no facilities for safekeeping of valuables. I do hereby release AAP from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to a AAP medical practice, office or facility. _____

NOTICE OF PRIVACY PRACTICES: Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have been offered a copy of CPC's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated using virtual health or telemedicine services, as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received. _____

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested. _____

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has been offered a copy of. I hereby agree with all the terms and conditions set forth above and understand that **any section of this consent that I do not consent to, I have struck through** and initialed the section that does not have my consent or permission. I agree this auto renews each year unless I notify AAP otherwise.

_____	_____
Signature of Patient or Parent/Legal Guardian/Authorized Representative	Relationship to Patient if Applicable
_____	_____
Witness to Signature	Date/Time of Signing