General Consent Agreement

Patient: _____ Date of birth: _____

Consent for Medical Treatment:

I consent to let the clinical providers and employees of **Blanchard Valley Pediatrics** (the practice) do all things that may be needed to diagnose, treat and care for the needs of the patient referenced below to include any necessary examination, immunizations, medical diagnosis, surgery, treatment and/or hospital care to be rendered to the minor child named below under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the State of Ohio.

I authorize the practice to take photos, video or audio recording of me/my child for diagnostic and identification purposes.

I understand that the practice is not responsible for personal belongings lost during my visit.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me about the result of my examination or treatment.

Patient Rights and Responsibilities:

I understand I have the right to take part in decisions about the health care and plan for treatment. I have received a copy of the Patient Rights and Responsibilities and my questions have been answered.

Consent to Release Medical Information:

I consent to let the practice share/release/exchange information such as clinical research, physical, mental, drug alcohol, HIV or AIDS (including information that state and federal law and accreditation agencies require) to/with my doctors, health care provider, and/or to any insurance company or organization that helps pay my bill. The practice may also give information to any welfare organization to which I have applied or may apply for aid.

Assignment of Insurance Benefits:

I assign to the practice, my physician and other healthcare professionals involved in the patient's care, all my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs I identify for which benefits may be available to pay the practice for medical services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

Practice Price Disclosure:

I have a right to see a list of prices for services provided.

Patient: _____Date of birth: _____

Financial Responsibility:

I (or my guarantor, if appropriate) will pay all bills for care including bills that insurance benefits do not pay. This includes bills from the practice, physicians or any other entities that provided services during my care.

Removal from the practice:

If I decide to stop medical care against the advice of doctors, I understand that the practice and doctor(s) are not responsible for any bad result after I leave.

Acknowledgment of Receipt of Notice of Privacy Practices:

I hereby acknowledge that I was offered a copy of the Notice of Privacy Practices which sets forth the ways in which protected health information may be used or disclosed by the practice and outlines my rights with respect to such information.

Consent for Automated Calls and Texts:

I authorize the practice, its affiliated entities, and third-party service providers to call or text me at any wireless phone number associated with my account(s), including any phone number that may result in charges to me, whether provided in the past, present, or future. I agree that methods of contact may include use of pre-recorded or artificial voices or an automatic dialing system. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services from the practice.

I **do not** wish to receive text messages or automated appointment reminders. _____**initial**

Acknowledgement of Receipt of Children's Community Practice Patient Policies:

I hereby acknowledge that I was offered or received a copy of the Children's Community Practice Patient Policies, which set forth the responsibilities a patient must abide by as part of this physician practice.

BY SIGNING, I CONFIRM THAT I HAVE LEGAL ABILITY TO CONSENT FOR THE TREATMENT.

Patient Name(s) _____
___

Signed _____ Signed _____
PATIENT, IF 18 YEARS OR OLDER DATE TIME PARENT/GUARDIAN, IF PATIENT IS LESS THAN 18 YEARS DATE/TIME

_____(_____)_____
STREET ADDRESS CITY STATE ZIP CODE AREA CODE PHONE NUMBER

Signed _____ _____
WITNESS DATE TIME PRINT NAME OF PARENT/GUARDIAN