Metropolitan Pediatrics

GENERAL CONSENT

Consent to Treat:

I consent to and authorize the physicians, nurses and other healthcare providers at Metropolitan Pediatrics to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

Metropolitan Pediatrics is a teaching clinic. In addition to my clinician and other medical support staff, I may receive care from people who are in training. They are supervised by licensed health care providers. I may decline to have these individuals involved in my care and this will not affect my care or treatment.

Assignment of Benefits and Payment for Services:

I authorize payment of any and all benefits to Metropolitan Pediatrics. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with Metropolitan Pediatrics to get payment for my care. If I am eligible for payment from more than one type of coverage, Metropolitan Pediatrics will return any extra payments to the payor. If I have an unpaid bill at Metropolitan Pediatrics, any refunds due to me will be put on my unpaid bill. If there is money left over after my bill is paid, I will receive a refund from Metropolitan Pediatrics.

Release of Information:

I consent to an authorize Metropolitan Pediatrics to use and disclose my protected health information for:

- Treatment;
- Payment; and
- Healthcare operations, including care coordination and quality assessment and improvement activities.

Releases for these purposes may be made to insurance companies, health plans, government programs, e-prescriber databases, payer network organizations, including clinically integrated networks and/or accountable care organizations in which my provider participates, and other healthcare providers involved in my care and treatment. Additionally, I consent to and authorize my insurance company to share my protected health information for the purposes stated above to Metropolitan Pediatrics or a clinically integrated network or accountable care organization in which Metropolitan Pediatrics participates.

Patient Rights and Privacy Practices:

You and your family's rights and our privacy practices are posted in main areas within Metropolitan Pediatrics. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider of Metropolitan Pediatrics' Privacy Officer.

Other Individuals Authorized to Consent to Treatment:

In addition to the legal guardians of the patient, the following persons are authorized to consent to recommended medical care for my child, e.g., grandmother, grandfather, daycare provider, and so on.

Name:	Relationship to Child:	Phone Number:

My signature here means I have read this information and understand it. This consent is valid until revoked in writing.

Patient Name: _____ Date: _____

Signature: _____ Print Name: _____

Relationship to Patient: _____ Interpreter Name (if used): _____

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