Metropolitan Pediatrics

MEDICAL CONSENT FOR MINORS

Consent to Treat:

I consent to and authorize the physicians, nurses and other healthcare providers at Metropolitan Pediatrics to perform appropriate healthcare examinations, treatment, and 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.

Release of Information:

I consent to and authorize Metropolitan Pediatrics to use and disclose my protected health information for treatment, payment and/or healthcare operation purposes, 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 or Metropolitan Pediatrics' Privacy Officer.

Other Individuals Authorized to Consent to Treatment (Medical Authorization for Minors):

As agents for myself in my absence or incapacitation to consent to any phone triage advice, medical or surgical diagnosis or treatment, x-ray examination and/or anesthetic medical care which is deemed advisable by and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act at Metropolitan Pediatrics. In addition to the legal guardians of the patient, I do hereby authorize the following persons to consent to recommended medical care for my child: name and relationship to patient (e.g., grandmother, grandfather, daycare provider, and so on):

Name:	Relationship to Child:	Phone Number:

Mobile Phone Consent:

____ Yes, Metropolitan Pediatrics and its affiliates or contractors may call my mobile phone number recorded here about my care or my child's care, treatment, services and accounts using prerecorded messages, automatic telephone dialing systems and/or text messages.
____ No, I do not authorize Metropolitan Pediatrics and its affiliates or contractors to call my mobile phone number about my or my children's services and accounts using prerecorded messages, automatic telephone dialing systems and/or text messages.

I understand and accept each of the following:

- **Costs**. Standard text message and minute usage rates from my mobile or internet service provider may apply.
- **Privacy and Security**. Receiving voice and text messages from Metropolitan Pediatrics may impact the privacy and security of protected health information (PHI). Voice and text messages are not encrypted. Encryption makes sure information stays safe. Information in voice or text may not be secure.
- **Revocation**. This consent to receive voice or text messages on my mobile phone will be in effect until I have notified Metropolitan Pediatrics that I no longer want to receive messages on my mobile phone. I will let Metropolitan Pediatrics know if I no longer want to receive messages on my mobile phone.
- **Number change**. I will let Metropolitan Pediatrics know if my mobile number changes.

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): _____

Telephone Consent (name/date/title): _____