General Consent for Treatment

This consent will automatically renew annually for all children listed below, until you revoke this consent, in writing, except where we have already made disclosure in reliance on your prior consent.

Patient name: _____ Date of Birth: _____

Patient name: _____ Date of Birth: _____

Patient name: _____ Date of Birth: _____

Patient name: _____ Date of Birth: _____

Please list ALL individuals that are allowed to bring your child/children to The Pediatric Center:

(Please note that a printed clinical summary may be given at the time of the office visit but does not entitle said person to medical records.)

_____ _____

_____ _____

Consent for Diagnosis, Care, and Treatment

I understand and acknowledge that this General Consent for Treatment applies to the care and treatment my child/children receive at any or all locations of The Pediatric Center of Southwest Louisiana, herein referred to as The Pediatric Center. This may include but is not limited to routine diagnostic, radiology, and laboratory procedures and medication administration. It will be valid from the date of my signature.

I consent to and authorize the physicians and other health care providers who may be involved in the care of my child/children to provide such diagnosis, care, and treatment considered necessary for their well-being.

I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at The Pediatric Center. I understand that health care providers in training, including nursing, laboratory, and x-ray students, may be involved in the care and treatment of my child/children. I authorize the examination and disposal of all tissue, fluids, or specimens removed from their body.

Patient Rights and Responsibilities

I understand that I have the right, and the responsibility, to participate in the care and treatment of my child/children. I understand that I have the right to be informed about the treatment being recommended, the risks involved, and any alternatives available; and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my child/children's health history and presenting complaint, to agree upon a treatment plan, and follow that plan. I understand that the health care providers will treat me and my child/children with respect, and I agree to do the same for them. Not doing so may result in the dismissal of all my children from the care of The Pediatric Center.

HIPAA - Use and Disclosure of Health Information

I understand that The Pediatric Center will use and disclose my health information for the purposes of treatment, payment, and healthcare operations. I understand, acknowledge, and consent to the release of my child/children's personal health information for the purposes outlined in this section, and as described in the Notice of Privacy Practices which is available to me online at **thepediatriccenter.com**, and in printed form, and as may otherwise be permitted by law. I also understand that it is my responsibility to review it.

We will not use or disclose your P.H.I. for any purpose not mentioned in the Notice of Privacy Practices without your specific written authorization. Any specific authorization you provide may be revoked at any time by writing to the Compliance Representative at the address noted below. If you think privacy rights have been violated, submit a written complaint to the Compliance Representative noted at the end of this consent. You may also submit a written complaint to the U.S. Department of health and Human Services. We will provide you with this address upon request. We will not retaliate in any way if you choose to file a complaint. If any changes occur in the Notice of Privacy Practices for The Pediatric Center of Southwest Louisiana, it will be available on our website. A printed copy of this change will be available upon request.

I understand that The Pediatric Center may record medical and other information related to my child/children's treatment in paper, electronic, photographic, video, and other formats and that such information will be used during their treatment, for payment purposes, and to support healthcare operations.

I give consent for treating physicians and other health care providers to exchange information with other health care professionals, businesses, and providers including but not limited to hospitals, home health agencies, state agencies, and pharmacies about my child/children's prior and current health conditions to facilitate treatment or for continuation of care. This includes any and all information, test results, and records regarding treatment for drug or substance abuse, mental health, HIV or AIDS, and infectious disease reporting.

Health Information Exchanges

Health information exchanges allow health care providers to share health care information about patients electronically for several purposes, such as treatment, quality assurance, and state law reporting requirements. I understand that if I go to The Pediatric Center for treatment, the physicians and/or their staff may get a copy of my medication history, send and receive immunization records, and send and receive other health care information electronically through various health information exchange connections with other health care providers. I understand I may request that my health care information not be shared through electronic health information exchange by following the directions in the Notice of Privacy Practices.

Personal Property and Valuables

I understand that my personal property is my responsibility, and The Pediatric Center is neither responsible nor liable for the loss, destruction, or theft of my personal property.

Communication

I agree that The Pediatric Center, or a vendor acting on their behalf, may communicate with me in writing to any address I have provided, communicate orally or by text message to any telephone number I have provided, including any cellular numbers which could result in charges to me, communicate electronically through any e-mail address I have provided, and electronically encrypted using Follow My Health Patient Portal. I agree that methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I understand that I will not be contacted in any way by telemarketers for or on the behalf of The Pediatric Center of Southwest Louisiana.

Submit questions and/or complaints in writing to:
Compliance Representative
The Pediatric Center of Southwest Louisiana
600 Cypress Street
Sulphur, La 70663

Mothers Name (Printed)_____Signature_____

Fathers Name (Printed)_____Signature_____

Legal Guardian (If not a biological parent)_____Signature_____

TODAYS DATE: _____