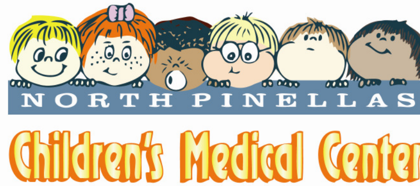

CONSENT AND AGREEMENT FOR TREATMENT

Please read the following information carefully. After you have read this Consent and Agreement, please sign your name below to accept the terms of this agreement.

1. ***Consent to treat:*** As a consenting adult, I agree to permit the staff of North Pinellas Children's Medical Center to provide medical care to my child/children.

2. ***Teaching facility:*** As a patient of North Pinellas Children's Medical Center, all treatment will be provided by physicians, staff members, students and residents under the supervision of the physician.

3. ***Patient Rights under HIPAA (If any of these pertain to you, please notify the front desk manager):***
   - Ask to view or get a copy of your child/children's records. A reasonable fee may be charged for copies provided.
   - Ask for corrections to be made to your child/children's records
   - Receive a notice of how your health information may be used and shared (HIPAA Privacy Practices)
   - Request a restriction from others' accessing your child/children's records. In the case of custody and other court orders, a full copy of the signed court documentation must be provided.
   - Request North Pinellas Children's Medical Center staff follow special instructions to communicate with you confidentially, other than what is provided on the patient registration form
   - Request a report on when and why your child/children's records were released without your consent
   - File a complaint with the provider and the US Government if you believe your rights have been denied or you feel your child/children's health information is not being protected

4. ***Right to discontinue treatment:*** It is the policy of North Pinellas Children's Medical Center to discharge a patient after three or more no show appointments or excessive cancellations. North Pinellas Children's has the right to discontinue treatment and discharge a patient for any appropriate reason, such as non-compliance with recommended care and treatment, problems between parents/family members that interfere with the child/children's care, no shows or excessive cancellations. In such cases, the parent or patient's representative agrees to accept full responsibility for pursuing alternate professional medical care. A letter will be sent informing the parent or patient's representative that treatment is being discontinued.

5. ***Medical Records Releases***: All records pertaining to the treatment and diagnosis of patients are the property of North Pinellas Children's Medical Center. Parents/patient representatives who have signed up for the Patient Portal have access to a summary of their child/children's visits at no charge. Parents/patient representatives who wish to receive a more detailed copy of the child/children's records or need them to be sent to another physician, e.g. moving out of the area or changing doctors, must complete an Authorization to Release Medical Records. The completed form with the parent/patient representative's original signature must be received by the office

before records may be released. If records are requested to be sent to a new provider directly, they will be provided at no charge. If records are sent to the parent or other party/non-provider, a reasonable processing fee allowed by the State of Florida will be charged. Payment of this fee must be received in our office prior to processing the medical record release.

6. ***NPCMC Patient Policies:*** The North Pinellas Children's Medical Center Brochure contains policies for each location's Office Hours, Scheduling Appointments, Refilling Prescriptions, Emergency Care, After Hours Access, and Referrals.

   I acknowledge I have received a copy of the North Pinellas Children's Medical Center Brochure.

   ________________________________ _________________

   Parent or Representative's Signature Date

7. ***Payment for services:*** I am expected to pay for the treatment I receive. North Pinellas Children's Medical Center has the right to revise fees at any time, for any services which have not yet been started. During the course of my medical care, worsening of symptoms or unexpected new conditions may arise that may require multiple visits to clinic and I understand that there will be a charge for each of my visits even if for the same condition.

8. ***Risks of treatment:*** The physician is available to answer any questions concerning the risks involved with specific treatment, procedures and immunizations. Informed consent will be obtain prior to any such treatment.

9. ***Follow-up appointments:*** I understand that by accepting treatment at North Pinellas Children's Medical Center, I also consent to future follow-up appointments for the purpose of assessing the outcome of the treatment or testing provided to the patient.

10. ***Consent to treatment:*** By signing below, I am indicating that I have read and I understand the terms of the Consent and Agreement for Treatment. I am either the parent or have the authority to give consent for the patient. I give consent to North Pinellas Children's Medical Center to perform necessary or appropriate tasks for proper medical care and physical examination, diagnosis, and treatment.

    My questions regarding this consent and agreement have been answered.

List Child's Name and Date of Birth for Each Child:____

____

____ ____________________________

Parent or Patient Representative Signature Date

____ ____________________________

If Patient Representative, Relationship to Patient Witness