Please list the names and birthdates of all children in the household:

Name ____ Date of Birth________________________

Name ____ Date of Birth________________________

Name ____ Date of Birth________________________

Name ____ Date of Birth________________________

Name ____ Date of Birth________________________

✓ **Consent to Treat** **Initial Here**____________________

You have the right, as a parent, to be informed about your child's condition and any recommended surgical, medical or diagnostic procedure so that you may make an informed decision, on your child's behalf, whether to undergo any suggested treatment or procedure based on the risks and hazards involved. At this point in your child's care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform reasonable and necessary medical examinations, testing and treatment for any identified condition(s). You have the right to discuss the treatment plan with your child's physician or advanced practice provider about the purpose, potential risks and benefits of any test ordered for your child. If you have any concerns regarding any test or treatment recommended, we encourage you to ask questions.

I voluntarily request a physician or advanced practice provider perform reasonable and necessary medical examinations, testing and treatment for the condition which has brought me to seek care for my child at this practice.

By signing below, you are indicating you (1) intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) consent for treatment by this practice. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

I understand that if additional invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

✓ **Credit and Collections Policy (HIPAA)** **Initial Here**____________________

I have been offered an opportunity to review the entire CCH credit and collections policy as part of this authorization process.

I authorize the release of all or any part of my child's medical record to persons, corporations, or other entities responsible for payment of all or part of my child's medical care including but not limited to insurance companies, employers, workers compensation carriers, or other entities providing billing, credit, payment or collection services on my child's account. I agree to pay Complete Children's Health for services rendered. I assign to Complete Children's Health all insurance benefits to which my child may be entitled to for the charges owed to Complete Children's Health. I agree to pay for all charges not paid by my child's insurance carrier.

✓ **No Show/Late Arrival/Late Cancellation Policy** **Initial Here**_______________________

We understand that there are times when scheduling conflicts arise, and you are unable to keep your scheduled appointment. We ask that you notify us at least 2 hours in advance so that we can schedule an appointment for another child who needs medical care. For Specialty Clinics such as Psychology appointments we require 24 hours' notice. For any missed appointment that is not cancelled in advance there will be a fee of $24.99 charged to your account.

We ask that you arrive 10 minutes early for your appointment to complete any necessary paperwork. This ensures that other scheduled appointments for the day are not disrupted and helps to keep everyone's wait to a minimum.

✓ **Telehealth Services** **Initial Here**________________________

In some situations, telehealth services can be offered/provided. Telehealth services can be refused or discontinued at any time without affecting your child's right to future care or treatment or any other benefits to which your child would be entitled to. If telehealth services are offered and declined, alternative options which may be available include in-person services. All existing confidentiality protections shall apply to the telehealth consultation. No patient identifiable images or information will be disseminated to researcher's other entities without written consent. Patients will have access to all medical information resulting from the telehealth services as provided by law for patients' access to their medical records.

✓ **Authorization Regarding Communication Methods** **Initial Here**________________________

I understand and agree that any cellular or land line phone numbers and email addresses provided to CCH, now and in the future, may be used as a means for contact and that CCH may leave messages manually or by using automatic systems such as by artificial or prerecorded voice or text and disclose the nature of the communication. This consent remains effective if a new or different cellular, landline or email address is acquired.

✓ **Signatures**

____ _________________________

Signature of Patient or Personal Representative Date

____ _________________________

Print Parent or Personal Representative First and Last Name CCH Witness