CONSENT FOR TREATMENT (Minor)

1. ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:
I hereby assign and authorize payment directly to ADVANCED PRACTICE NURSING SPECIALISTS (APNS), and to any APNS providers, all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for APNS, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of APNS in accordance with the regular rates and terms of APNS. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above APNS visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for APNS to appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):
I have been made aware and understand that the medical practices and offices may use an electronic prescription system, which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications my child is already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information. I have been provided the Electronic Prescribing Notice included in the Notice of Privacy Practices.

3. NOTICE OF PRIVACY PRACTICES:
Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of APNS's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at APNS, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4. GENERAL CONSENT FOR TESTS, TREATMENTS, AND SERVICES:
I agree and understand that all providers involved in my child's care in any way are responsible and liable for their own acts and omissions, and APNS is not responsible or liable for the acts or omissions of the aforementioned. Independent contractors, who are not employed by APNS, may perform services. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care, diagnostics, or examinations at APNS. I have been informed of the treatment procedures considered necessary for my child and that the treatments/ procedures will be directed by a provider and may be performed by such provider and/or one or more additional providers, nurses, staff and employees of APNS. I understand that one or more providers, fellows, residents, and/or interns at APNS may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding which providers and/or fellows, residents, or interns will treat my child or participate in my child's treatment and/or the results that may be obtained from treatment.

GENERAL CONSENT FOR TREATMENT OF A MIINOR
I have the legal right to consent to medical and surgical treatment because (a) I am the patient or (b) I am the legal guardian of the patient _____ (name of patient).

I voluntarily authorize and consent to the medical care, treatment, and diagnostics tests that the providers of APNS and their designated associates or assistants believe are necessary for my child. I understand that by signing this form, I am giving permission to the providers, nurses, and staff in this medical office to provide treatment to my child as long as a provider/patient relationship exists, or until I withdraw my consent.
_____ (Initial)

PARENTAL PREAUTHORIZATION FOR MINORS DELEGATION OF CONSENT

Name of Patient: _____

Patient's Date of Birth: _____

I hereby authorize (when I am unavailable to give consent) to the following individual(s):

_____	_____	_____
Name of Person	Relationship	Phone Number
_____	_____	_____
Name of Person	Relationship	Phone Number
_____	_____	_____
Name of Person	Relationship	Phone Number

To consent to any and all medical care and attention for my child that is deemed necessary and appropriate by a licensed healthcare provider of APNS. This consent includes but is not limited to emergency care, medical and surgical intervention, imaging, lab work, administration of medications, and elective procedures. This delegation shall be valid until I withdraw delegation of consent.

5. CONSENT TO PHOTO/VIDEO:
I consent to the photographing or videotaping, including appropriate portions of my child's body, for medical and medical record documentation purposes, provided said photographs or digital recordings are maintained and released in accordance with protected health information regulations.

6. EMAIL:
I hereby consent to provide my e-mail address, so that representatives from APNS can e-mail information to me about my child's health education or disease prevention and up-to-date information about APNS, its affiliated providers, and our services. I understand I will be able to change my preference at any time.

7. IMAGING SERVICES:
I hereby consent to allow APNS's Imaging Services to share my child's images and/or recordings with affiliated facilities, when requested, for continuing medical treatment.

8. CELL PHONES:
I hereby consent to provide my phone number(s), including my wireless telephone number(s), such that representatives from APNS, its successors or assigns can contact me regarding my child in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by emailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

9. AUTHORIZATION TO GIVE MEDICAL CARE – CONSENT TO TREATMENT:
I hereby voluntarily consent to outpatient care from and by APNS encompassing routine diagnostic procedures, examination, and medical treatment to and for my child, This consent includes, but is not limited to, emergency care, medical and surgical intervention, imaging, lab work, administration of medications, and elective procedures by the providers. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment from and by APNS providers and staff, as is necessary in the medical staff's judgment. I understand that during the course of treatment, health care workers may be exposed to the patients' blood and/or body fluids increasing their risk of contracting Hepatitis B, Hepatitis C, and/or HIV. In the event an exposure occurs, I understand the need for testing for these diseases and I agree to such testing of my child to promote the health and welfare of the health care worker. I understand that this consent will be valid and remain in effect as long as I attend the clinic.

10. AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize APNS to release any of my child's information acquired in the course of my examination and treatment to any authorized agent for the purposes of healthcare, treatment, and payment. I authorize the release of my child's medical information to my insurers as necessary for determination and payment of benefits; to healthcare providers involved in my care; to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs.

I understand that I may revoke this consent in writing; except to the extent that the organization has already taken action in reliance thereof. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me.

TO THE PARENT OR LEGAL GUARDIAN: You have the right, as a patient or legal guardian, to be informed about your child's condition and the recommended surgical, medical or diagnostic procedure to be used so that you, on behalf of your child, may make the decision whether or not to have your child undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for your child for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment for and on your child. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended for your child; and (2) you consent to treatment for your child at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Advanced Practice Nursing Specialists

You have the right to discuss the treatment plan with your 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 recommend for your child by your health care provider, we encourage you to ask questions.

I hereby voluntarily request a provider, and other health care staff, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, imaging, other diagnostics, medication administration, and treatments for the condition, which has brought my child to seek care at this practice. I understand that if certain testing, invasive or interventional procedures are recommended for my child, I will be asked to read and sign additional consent forms prior to said 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. My questions and concerns have been addressed to my satisfaction.

My signature below indicates that I understand and accept the contents of this form.

_____ Date Time _____AM/PM
Parent or Legal Guardian

_____ Date of Birth_____
Print Name

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