PEARLAND PEDIATRICS
& SPORTS MEDICINE

General Consent to Treat

I have the legal right to consent to medical and surgical treatment because (a) I am the patient or (b) I am the parent/guardian of the patient.
All references to "patient", "me" and "my" in this document means: **(List Name of Patient(s))** _____

_____.

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers at Pearland Pediatrics and their designated associates or assistants believe are necessary. I also consent to the taking of photographs or films related to the care and treatment of the patient and understand that such photographs or films may be made part of the medical record. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, nurse practitioners, and other health care providers in this medical office to provide treatment as long as a physician/patient relationship exists, or until **I** withdraw my consent.
_____ (Please initial)

Sharing Records for Treatment

We share medical records with other health care providers to allow and promote continuity of care among providers. If you visit another provider, they may have access to your medical record.
_____ (Please initial)

Acknowledgement of Financial Policy

I acknowledge receiving Pearland Pediatrics' Financial Policy. This Policy explains my financial responsibility and how any past due balances will be handled. ***A copy may be obtained through the front desk, if you should have questions please contact our Billing Manager at (281) 485-9990.***
_____ (Please initial)

Acknowledgement of role in Patient Centered Medical Home (PCMH)

Pearland Pediatrics has been awarded level 3 certification from the NCQA. This means you will be surrounded by a dedicated team of health professionals, working together with you, to optimize your health goals using the best evidence-based medicine and resources available for you today. By initialing below, you consent to participate fully in your healthcare, including notifying our office of any outside care received from any other provider such as seeing a specialist or visiting an emergency room, and addressing any obstacles that may affect the prescribed treatment plan.
_____ (Please initial)

Acknowledgment: Notice of Privacy Practices

I acknowledge receiving Pearland Pediatrics' Notice of Privacy Practices ("Notice"). The Notice explains how Pearland Pediatrics may use and disclose the patient's protected health information for treatment, payment and health care operations purpose. "Protected health information" means the patient's personal health information found in the patient's medical and billing records. ***If you have questions about the Notice, please contact our Office Manager at (281) 485-9990.***
_____ (Please initial)

Acknowledgment of Office Information & Policies

I acknowledge receiving Pearland Pediatrics' Office Information and Policies. By acknowledging this I am accepting the policies as stated. I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.
_____ (Please initial)

Patient's Name: _____Date of birth (MM/DD/YYYY):_____

Patient's Name: _____Date of birth (MM/DD/YYYY):_____

Patient's Name: _____Date of birth (MM/DD/YYYY):_____

Name of Patient's Representative, if patient under 18 (Printed): _____
Relationship of Patient's Representative if patient under 18:
_____

Signature of Patient or Patient's Representative: _____ Date: _____