Provider ID Group #: _____ Primary Coverage Member ID: _____

Secondary Coverage Member ID: _____

CONSENT FOR TREATMENT:

- I consent to receiving care at this Facility which is necessary or beneficial, including, but not limited to, the administration of medications, injections, x–ray examinations, laboratory procedures, and hospital services as may be deemed necessary or advisable by my care provider(s).
- I understand that care provider(s) may not be employed by or agents of Facility but has/have the right to practice medicine at Facility. I may be billed separately for services provided by these providers.
- I understand that my healthcare team may be comprised of physicians, physician assistants, fellows, nurse practitioners, nurses, technicians, residents, students, other employees, and agents.
- I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees are made as to the results of my treatment or procedures performed.
- I understand that during my treatment photographing, videotaping, audio recording, and/or televising (Recordings) may occur for care/treatment or identification purposes and will become part of my medical record.
- I understand that Recordings may be taken for education, training, educational/research publication, or quality assurance purposes. These recordings will not reveal my identity and will not become part of my medical record.
- I understand that I have the right to refuse any medications, treatment, procedures, or Recordings to the extent permitted by law.

PROHIBITION OF WEAPONS/HAZARDS/DRUGS:

- I understand that for my health and protection, as well as the protection of others, I am not permitted to bring or have any weapons, illegal substances or drugs, hazardous materials, alcoholic beverages, smoking materials or unauthorized electrical appliances on my person, or in my belongings. I understand that the Facility may search my belongings, as well as confiscate and dispose of any of these prohibited items, including providing them to law enforcement.

AUTHORITY TO REVIEW AND RELEASE RECORDS AND INFORMATION:

- I understand confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS, or drug or alcohol treatment is maintained per relevant governmental and regulatory standards.
- I authorize release of medical information for my minor child necessary for the use of medical treatment of the child by the Physician, Facility, or other medical providers who have, or will render care including test results, treatment, therapy and other medical management. If I am a Managed Care subscriber, I authorize access to my minor child's medical record for payment, authorizations and Quality reviews.

HEALTH INFORMATION EXCHANGES (HIEs) PARTICIPATION:

- I agree to participate in "Health Information Exchanges (HIEs)," which allow my healthcare providers to access my protected health information from other participating providers from whom I have received care.
- I understand that I have the option to "opt out" from sharing my protected health information with the HIEs.
- I understand if I choose to "opt out" that my choice will not affect my ability to receive medical care.

CONSENT FOR TREATMENT

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES:

- I understand that St Christopher's Pediatric Associates does not accept responsibility for loss or damage to any monies, valuables, and/or personal property brought to St Christopher's Pediatric Associates.

PATIENT RIGHTS AND RESPONSIBILITIES:

- I understand that I have patient rights which reflect St Christopher's Pediatric Associates's commitment to maintaining my personal dignity while providing me with the healthcare services I need.
- I understand that I have responsibilities to provide the healthcare team with certain information and support.
- I understand that I have the responsibilities to respect the rights of others.
- I understand that if I have any concerns regarding my care, I may talk with my doctor, nurse or any member of my healthcare team.

PHOTOGRAPHY/RECORDING BY PATIENTS AND VISITORS:

- I understand that any type of Recording is strictly prohibited without the verbal consent of a healthcare provider or staff member.
- I understand that Recording must not interfere with patient care.
- I understand that individuals Recording without consent or whose Recording is deemed to interfere with patient care may be asked to stop the Recording and could be asked to leave the premises.
- I understand it is my responsibility to ensure my family and visitors comply with these requirements.

MEDICAL ASSISTANCE VERIFICATION:

- If I am a recipient of Medical Assistance, I certify that I received a service or item on the date listed below. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements or documents, or concealment of material information may be prosecuted under applicable Federal and State laws.

ACKNOWLDGEMENT FORM:

- I have read this form (or have had it read to me) in its entirety, have had any questions answered to my satisfaction, consent to each of the above provisions, and am signing this form knowingly and voluntarily.

_____	_____	_____
Signature of Patient or Authorized Individual	Date	Time
_____	_____	
Printed Name of Patient or Authorized Individual	Relationship to Patient	