Consent for Treatment

Please read this form. Ask questions about anything you do not understand before you sign.

Treatment

- I authorize Children's Medical Group (CMG) doctors, nurses and other employees to evaluate and treat my child. This may include, but is not limited to, physical examinations, administering or prescribing medications including immunizations, and performing or ordering procedures and tests.

- There are mental health providers located at some of the CMG locations. I authorize a mental health provider to perform a screening of my child. I may receive an additional bill for this screening.

- CMG supports training and teaching of health care professionals. Students may be involved in providing my child's care.

Patient Rights and Privacy

- Patient/Family Rights and Responsibilities information is posted in each CMG waiting room. I may request a copy. It is also available at CHW.org.

- I received the Notice of Privacy Practices. It explains how my child's health information may be handled and is posted in each CMG waiting room and is available at CHW.org.

- Medical Records may be shared with health providers, insurance companies and Children's Hospital and Health System for treatment, payment and health care operations.

- Photographs and recordings may be taken by CMG for care, training, education or security purposes. I am not allowed to take photos or videos of other patients or of staff when they are providing care to my child.

Financial Agreement

- CMG will bill my insurance company for services provided. I am responsible for charges not covered by insurance. Co-pays are to be paid at the time the service is rendered. Non-payment will result in an account being referred to a collection agency.

Communication

- You may need to call, email or text me about appointments, treatment, billing and collections. Pre-recorded messages and auto-dialers may be used when contacting me. I give you permission to contact me at all of the telephone numbers/email addresses provided and know that may result in charges to me.

I have read this information. I am legally able to consent for my child. By signing this form, I give my permission for treatment and agree to the terms listed above. My consent for CMG visits is valid for one year.

Signature: X ____________________________ Relationship to Patient: ____________________________

Patient, Parent or Legal Guardian  Verbal Consent: ☐ Yes ____________________________

Date: ___________  Time: ___________

CMG Witness to the Signature  Second CMG Witness to Verbal Consent

C8010N (11/17)