EAGAN VALLEY PEDIATRICS PA
General Consent

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Consent to Treat
I consent to and authorize the physicians, nurses and other healthcare providers at Eagan Valley Pediatrics, PA to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

Assignment of Benefits/Payment for Services
I authorize payment of any and all benefits to Eagan Valley Pediatrics, PA. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with Eagan Valley Pediatrics, PA to get payment for my care. If I am eligible for payment from more than one type of coverage, Eagan Valley Pediatrics, PA will return any extra payments to the payor. If I have an unpaid bill at Eagan Valley Pediatrics, PA, any refunds due to me will be put on my unpaid bill. I further understand that future services may be denied with the non-payment of my account. If you No Show for more than one appointment in a 12 month period there will be a charge of $50 that you will be responsible for. Insurance does not cover this cost.

Lab Results
I give permission to Eagan Valley Pediatrics to leave a message for (Parent 1 name and phone) _____,

(Parent 2 name and phone)_____re: lab or test results.

Release of Information

I consent to and authorize Eagan Valley Pediatrics, PA to use and disclose my protected health information for:

- Treatment
- Payment

Releases for these purposes may be made to insurance companies, health plans, government programs, e-prescriber databases, payer network organizations, including clinically integrated networks and/or accountable care organizations in which my provider participates, and other healthcare providers involved in my care and treatment. Additionally, I consent to and authorize my insurance company to share my protected health information for the purposes stated above to Eagan Valley Pediatrics, PA or a clinically integrated network or accountable care organization in which Eagan Valley Pediatrics, PA participates.

Patient Rights and Privacy Practices
You and your family's rights and our privacy practices are posted in main areas within Eagan Valley Pediatrics, PA. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider or Eagan Valley Pediatrics, PA's Privacy Officer.

Reference Laboratory Services
I understand that Eagan Valley Pediatrics, PA utilizes the services of Health East Laboratory to perform some of the lab tests requested by our physicians. I further understand that Health East Laboratory will bill separately for its services. I consent to Eagan Valley Pediatrics, PA providing demographic information as necessary for billing purposes.

My signature here means I have read this information and understand it. This consent is valid until revoked in writing.

Signature: _____ **Print Name:** _____

Relationship to Patient: _____ **Parent Email:** _____

Name of Interpreter (if used): _____ **Telephone consent obtained by (Name/Date/Title):** _____