CONSENT FOR CARE, RELEASE OF INFORMATION, ELECTRONIC PRESCRIBING, FINANCIAL AGREEMENT, AND ASSIGNMENT OF INSURANCE BENEFITS

Today's Date: _____

Thank you for choosing the Cleveland Children's Clinic, a provider for your child's healthcare needs. Please read the following summary of our financial policy and sign/initial where indicated.

Initial Each

___**CONSENT FOR CARE:** I hereby give my consent for treatment at the Cleveland Children's Clinic

_____**RELEASE OF INFORMATION:** I grant consent to the Cleveland Children's Clinic to use and disclose my protected health information for the purposes of treatment, payment, and health care operations. My signature below indicates that I have been provided the Cleveland Children's Clinic's Notice of Privacy Practice (NPP). It describes my rights and the duties of the Cleveland Children's Clinic with respect to my protected health information, and provides more detailed information about how they may use and disclose my protected health information. I understand that I have the right to request a restriction as to how my protected health information may be used, but that Cleveland Children's Clinic is not required to agree to the action in reliance on the consent. The Cleveland Children's Clinic reserves the right to change the NPP, and I understand that I may request and obtain a copy of the revised Notice.

I hereby authorize Cleveland Children's Clinic to disclose my child's health information to other ____**Establishments or individuals participating in my child's care**.

Do not disclose my protected health information to the following (if any):
_____
_____

___ **ASSIGNMENT OF BENEFITS**: I request that payment of authorized Medicaid and/or insurance benefits be made on my behalf to Cleveland Children's Clinic for any services furnished me, I authorize any holder of my medical information to release information needed to determine these benefits to CMS (Centers for Medicare and Medicaid Services), its agents, or any insurance carrier I may have. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

___**FINANCIAL AGREEMENT**: I agree that I am responsible for payment for services provided by Cleveland Children's Clinic. If uninsured, payment is required on the day of service. If insured, I understand that claims will be filed with my insurance company, and that I am responsible for any co-payments, co-insurance, and/or deductibles as designated by my health plan. I understand that the authorized co-payment of my health plan is to be paid on the date of service. I understand that it is my responsibility to inform the Cleveland Children's Clinic of any

changes in my personal information or insurance information, and that it is my responsibility to obtain appropriate referrals if required by my insurance company. If my account is sent to an attorney or collection agency for collection, I agree to pay all collection expenses and attorney's fees. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. I agree that Cleveland Children's Clinic or any servicing agency retained by the facility to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors, may contact me by automatic dialing devices and through pre-recording messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any email address I provide to the facility or is otherwise associated with my account.

_____**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY**: I have received a copy of the Notice of Privacy Practices as required by HIPAA Privacy Regulations.

Initial Each

AUTHORIZATION TO LEAVE MESSAGE

_____I hereby authorized Cleveland Children's Clinic to leave messages regarding appointments or tests at my residence or cell phone.

AUTHORIZATION TO SEND APPOINTMENT REMINDERS OR OTHER ALERTS VIA TEXT MESSAGE OR AUTOMATED VOICE MESSAGING

_____ I hereby authorize Cleveland Children's Clinic to send appointment reminders to me via text message or automated voice message system. It is my responsibility to provide Cleveland Children's Clinic with the most up to date contact information.

PHOTO CONSENT

_____ I hereby authorize Cleveland Children's Clinic to take my child's picture for my electronic medical record.

PRESCRIPTION CONSENT

_____ I hereby authorize Cleveland Children's Clinic to electronically access my prescription history through a prescription database compiling all prescription history.

Signature, Patient or Legal Representative

If Signed by Legal Representative, Print Name & Relationship