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NEW PATIENT CONSENT FOR TREATMENT

Patient Name (Last, First)_____

Patient DOB _____

1. Patient rights and responsibilities / Practice philosophy
Thank you for trusting Prairie Pediatrics ("Practice") with your child's healthcare. We strive to provide care that is exemplary in quality and compassionate in delivery. In treating your child, we follow guidelines set out by the American Academy of Pediatrics to deliver evidence-based recommendations. As a patient, you have the right to hear options for your care along with my professional assessment and advice. We practice shared decision making with families whenever possible and provide care in a developmentally appropriate way.

In order to help your child, you agree to provide accurate information about their health, including their medications, allergies, past medical history, family medical history and social history.
INITIAL HERE_____

2. Privacy
You acknowledge and authorize Practice to use and/or disclose your health information that specifically identifies you, or that can reasonably be used to identify you, to carry out your treatment, payment, and healthcare operations. Practice will adhere to its obligations regarding your privacy rights as identified in Practice's Patient Notice of Privacy Practices.

If you initiate a conversation in which you disclose protected health information on a non-secure platform, Practice may communicate with you regarding protected health information in the same format. However, Practice may decline to communicate via any methods deemed non-secure.
INITIAL HERE_____

Communications technology and platforms are wholly outside the control of the Practice. Communications via text, messaging platform, audio or video call, by their nature, cannot be guaranteed to be secure and confidential. There is some risk that your personal information may be seen, accessed, copied or used by an unauthorized person or entity. Therefore, your provider and Practice shall not be liable to you, or anyone, for any cost, damage, expense, injury, or other loss relating to Communications malfunction, interception, or delay in response.
INITIAL HERE_____

3. Vaccine Policy
Vaccines are lifesaving and safe. Practice follows the vaccination schedule published by the Center for Disease Control. Failure to adhere to the vaccination schedule resulting in delays of 6-12 months will result in dismissal from the practice.
INITIAL HERE_____

I consent to have my child's vaccinations entered into the Colorado state immunization registry.
INITIAL HERE_____

4. Communication
The practice REQUIRES all patients to use our preferred patient portal and/or secure messaging app. You should ensure your phone notifications for the portal/app are turned on to ensure you receive all messages from the Practice.

- Do not directly text the practice - use the secure messaging instead. We cannot communicate via regular text for security reasons.
- Please read all portal messages and auto-responses to your messages carefully. They will advise you on expected timing for responses, instructions for urgent issues, pre-appointment information, etc.

INITIAL HERE_____

5. Financial Responsibility
You agree to assume financial responsibility for all services provided by the Practice based on the fee for service in effect at the time you receive care. If you are enrolled in a government or commercial health insurance plan, we will bill your plan for services provided. This does not ensure payment by the insurance company. You are responsible for knowing your plan benefits, verifying network status of the Practice and consulting your insurance carrier with any questions or concerns related to your coverage
INITIAL HERE_____

Your insurance may determine that you are responsible for payment related to copays, deductibles, co-insurance amounts, out-of-network services and/or services they deem "not covered". In this case, you will be billed by the Practice for all amounts not covered by insurance.

- You agree to pay all invoiced charges promptly upon the receipt of invoices.
- Failure to pay for services within 90 days of receiving an invoice may result in interest charges and/or dismissal from the Practice. We appreciate your prompt payment.
- Payments returned due to insufficient funds will result in a $30 charge to your account.
- You authorize Practice to bill and collect for services provided under this Agreement and in accordance with all Office Policies as maintained on our website.

INITIAL HERE_____

You may choose to "self-pay" for services for any reason, including not having active insurance or being enrolled in a medishare plan. In this case, insurance will not be billed and you will pay for services at the time of service at a discounted rate. You must notify the Practice at check in if you will "self-pay" - discounts cannot be applied after the date of service.
INITIAL HERE_____

6. Virtual Care via Patient Portal and/or App

Medical advice may be provided electronically via a patient portal or secure messaging app, as a courtesy to the patient. It is in the sole discretion of the treating provider as to whether an issue may be managed electronically and/or whether another treatment option (ie, telehealth visit, in-person visit, emergency room visit, etc.) is required.

Portal or app messaging requiring review of photographs, review of documents/assessments, the writing of orders or prescriptions and/or multiple questions/requests will be billed based on the time spent by the physician. For portal inquiries requiring follow-up beyond an initial response, patients will be offered an in-person or telehealth (if appropriate) visit to address their concerns. Your insurance plan will determine the portion of charges billed for any appointment or non-appointment time that may be your responsibility.

INITIAL HERE_____

Practice and our providers shall not be liable to you, or anyone, for any cost, damage, expense, injury, or other loss relating to Communications, malfunctions, or delays in response.

INITIAL HERE_____

7. Telehealth

Telehealth visits may be offered as a courtesy to the patient. It is in the sole discretion of the treating provider as to whether telehealth is offered and/or whether a telehealth encounter needs to be converted to another treatment option (ie, in-person visit, emergency room visit, etc.) due to clinical or non-clinical issues that may arise during the encounter.

- It is your responsibility to be in a private and safe space for the appointment where you can devote your attention to the treating provider's assessment and advice.
- You must be physically located in the state in which your provider is licensed.
- If you are temporarily out-of-state, the provider may not be able to issue prescriptions, referrals, or other orders. You may need to seek local care.
- Do not allow a health issue to remain unaddressed due to communication issues during a telehealth.

INITIAL HERE_____

8. Emergency care

Practice operates during regular business hours and is not available for care that requires immediate or urgent attention. Services are provided by appointment only and walk-in visits are not provided.

INITIAL HERE_____

If you are experiencing a medical or psychiatric emergency, you should immediately call 911 or your nearest emergency department. If you are experiencing an urgent healthcare need that cannot wait up to 48 hours for a response, or the next regular business day including holidays, whichever is later, then you should immediately call or go to your local emergency or urgent care center.

INITIAL HERE_____

9. Termination

The Practice may terminate any patient relationship at any time at their discretion by providing you with thirty (30) days' written notice. Potential reasons for terminating the relationship could include:

i. Failure to pay fees and charges when they are due.
ii. Failure to adhere to the recommended treatment plan, especially regarding the use of controlled substances.
iii. Failure to adhere to recommended vaccine schedules.
iv. Disruptive or abusive behavior that presents an emotional or physical danger to staff, patients, or others.
v. Practice discontinues operation.

Your signature indicates that you have read, understand and agree to all terms in this Agreement and that you have been given a copy of such or opted to use a digital copy. If you are enrolling patients other than yourself, your signature means that you have the authority to act on their behalf and you are financially responsible for services they receive under this Agreement.

Signature _____ Date _____

Relationship to Patient _____