5680 N. Tower Rd., #120
Denver, CO 80249

Phone: (720) 734-8816
Fax: (720) 405-4454
www.prairiepeds.com

NEW PATIENT CONSENT FOR TREATMENT

Patient Name (last, first)____

Patient DOB ____

1. Patient rights and responsibilities / Practice philosophy
Thank you for trusting me with your child's healthcare. I strive to provide care that is exemplary in quality and compassionate in delivery. In treating your child, I will 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. I 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
Your Privacy Rights. 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. Methods of Communication. You acknowledge that Practice communications may include use of cell phones, e-mail, facsimile, text messaging, and video (collectively, "Communications"). If you initiate a conversation in which you disclose protected health information on any of these Communication platforms, then you authorize Practice to communicate with you regarding all protected health information in the same format. 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________

3. Financial Responsibility and Notice of Advance Beneficiary
In exchange for Services, you agree to pay Practice the fee for service then in effect at the time you receive care. If you are enrolled in any health insurance or benefit plan for which we are in-network, we will bill your plan for covered services. If you have an out-of-network plan, as a courtesy to you, we will submit billings on your behalf. Please be aware that your insurance may deny services as "not covered." In that case, you are responsible for payment. We suggest that you review your insurance policy to understand what is covered and what is not. Please direct questions to your insurance company, as we cannot be responsible for knowing the details of

every plan. Insufficient funds or chargebacks may result in a charge on your account of $25, and overdue accounts may be subject to interest. You agree to keep your account current and pay fees and charges when they are due. 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__________

4. COMMUNICATION

Patient can communicate with Practice through “Spruce” which is an encrypted messaging app. Messages should be sent using the secure features and answers will be sent securely back. If you text message without the secure feature, you are consenting to all communication in this format. Messaging is offered as a service to the patient for nonurgent issues only. Requests for routine appointments, forms and medication refills will be responded to in 1-2 business days. Requests for non urgent medical advice will be triaged and responded to as clinically appropriate. If a question requires the physician to gather more information, make clinical judgements, and write orders or prescriptions, you will be offered a phone, telehealth or in-person appointment as appropriate. These appointments are billed to your insurance plan and the insurance plan determines the portion that is your responsibility.

For urgent concerns after hours, you may call the office at 720-734-8816. The physician on call will refer you to the Emergency Department or make arrangements to see you in the office the following day. A telehealth appointment may be offered which is billed to your insurance plan. Your insurance plan determines the portion that is your responsibility.

INITIAL HERE_______________

4. 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. 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 present at your local emergency or urgent care center. INITIAL HERE__________

6. Vaccine Policy

Vaccines are lifesaving and safe. I follow the vaccination schedule published by the Center for Disease Control. If you would like to follow an alternate vaccination schedule, you will agree in writing to the alternate schedule. 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__________

7. Telehealth

Telehealth is offered as a courtesy to the patient. It is the absolute discretion of the treating provider as to whether telehealth is appropriate. If issues arise during the course of a telehealth

visit that cannot or should not be treated remotely, whether it relates to the clinical issue or the communication platform (for example, poor connectivity), the provider will stop the visit and make alternate arrangements including potential referral to the nearest Emergency Department. If communication fails, you should attempt to contact the provider using another method. Under no circumstances should you allow a health issue to remain unaddressed due to communication issues or telehealth status. 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. At each Telehealth session you must be physically located in the state in which your provider is licensed. If you are temporarily out-of-state, but maintain in-state residency, you must notify your provider before a Telehealth session commences. You provider may not be able to issue prescriptions, referrals, or other orders if you are out-of-state. You may need to seek local care for these and other healthcare needs.

Communications technology and platforms are wholly outside the control of your provider and 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.

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. Disruptive or abusive behavior that presents an emotional or physical danger to staff, patients, or others.
iv. Practice discontinues operation.

Your signature indicates that you have read, understand and agree to all terms in this Agreement, the Notice of Patient Privacy Practices and the Telehealth Informed Consent 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 ____