Consent for Care and Treatment of a Minor Patient

Legal Guardian:

Authorization to Release Information and Assignment of Benefits: I given consent, by signing this document to Aurora Pediatrics to release the personal data as well as all or part of my child's medical record as required during examinations and treatment for purposes of billing and filing for insurance coverage or other financial claims related the care provided. I consent to assign all payments for services to Aurora Pediatrics or persons billing on their behalf, for care performed or services rendered by the provider where within to the patient named below. I also understand that Alaska State Law requires Aurora Pediatrics to report all vaccine records to the Alaska State Vaccine Registry.

Assumption of Financial Responsibility: I, by signing below, assume financial responsibility for payment of fees that occur from care rendered or services provided by Aurora Pediatrics to the patient named blow. Insurance or other coverage may pay for part of these charges, and I assume financial responsibility for any unpaid portion. I understand that pricing information is available upon request at the office and descriptions of services may be found on our website at www.aurorapediatricsak.com under the SERVICES tab. In accordance with Anchorage Municipal Code 16.130.010 (A Healthcare Transparency Policy) Aurora Pediatrics will provide you with an estimate of the anticipated charges and fees for you care upon request. Questions are welcome at any time. I also agree that if outstanding balances or arranged payment plans are not paid my account will be sent to a collection agency and I will be financially responsible for any additional fees or charges.

HIPPA Notice of Privacy Practices: I understand that Aurora Pediatrics provides the opportunity to view and receive a copy of the HIPPA Privacy Practices and the rights I have regarding health information. This information is available in the waiting room, each exam room, and on the website.

Discrimination: I understand that Aurora Pediatrics complies with applicable Federal Civil Rights laws and does not discriminate based on race, color, national origin, age, disability, orientation, or gender identification. Please note that TTY is not available in the office. If ASL interpretation is required, please inform the office as soon as possible so that appropriate services can be arranged.

Consent for Care: You have the right, as the parent/guardian of a minor child, to be informed about the patient's condition and the recommended surgical, medical, or diagnostic procedure(s) to be utilized so that you may make the informed decision whether to accept any suggested treatment or procedure after knowing the risks and benefits involved.

This consent provides us with your permission to perform or provide reasonable and necessary, medical examinations, testing treatment and vaccines. Vaccines are offered and provided in accordance with the Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP) recommended vaccination schedule as a standard of care at every visit a vaccine is due. Vaccine information will be provided to the Alaska State Vaccine registry (VacTrAK), along with all other approved agencies upon request. You have the right, at any time, to decline or discontinue any or all services. You have the right to discuss the treatment plan and any orders with the provider as well as the purpose, potential risks and benefits, or other questions concerns.

By signing below, you are indicating that you consent for care provided to the minor patient at this office by any Provider or other designated individual associated with Aurora Pediatrics. The same care will be provided to the minor patient regardless of who accompanies the minor child, or should the child come unaccompanied. The ability to discuss patient information is kept to a strict adherence to HIPPA standards and will be limited as necessary to adhere to those standards.

This consent will remain in effect for 1 year, or until is revoked in writing or the minor patient ceases to be a minor under the law. If additional testing, invasive or interventional procedures are recommended, you will be asked to read and sign additional consent forms prior to the test(s) or procedures(s).

I certify that I have read and fully understand the above statements and herby consent fully and voluntarily to its contents.

Patient Name____ DOB______________________

Parent/Guardian Name____ DOB______________________

Relationship to minor patient____________________________________

Signature____ Date______________________

For Aurora Pediatrics Staff Only: Staff______________________ Scanned to chart_________________