Children's Oasis Pediatrics - 1425 W Elliot Road, Suite 204, Gilbert, Arizona 85233

Patient Consent for Use and Disclosure of Protected Health Information and Office Policy

As parent/guardian of _____, I understand that as part of my child/children's health care Children's Oasis Pediatrics originates and maintains health records. These records describe history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I also give my consent for the patient(s) to receive medical evaluation and treatment by the providers at Children's Oasis Pediatrics. (I have been provided the opportunity to view the Notice of Information Practices that describes uses and disclosures of my child's Protected Health Information (medical record). I understand that I have the right to review the notice prior to signing this consent.)

With my consent, Children's Oasis Pediatrics may call (including leaving voice mail messages) or mail my home regarding items that assist the practice in carrying out treatment, payment, and health care operations, such as an appointment reminder, normal laboratory results and insurance items.

Permission to Treat
I give permission for Children's Oasis Pediatrics to provide medical treatment for my child.

I understand that Children's Oasis Pediatrics has the right to change its notice and practices. I understand that I have the right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment, or health care operations and that Children's Oasis Pediatrics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Children's Oasis Pediatrics has already taken action. If I do not sign this consent or revoke it, Children's Oasis Pediatrics may decline to provide treatment to my child.

I am aware that according to my insurance plan I am responsible for all co-payments, deductibles, and co- insurance. **Co-pay/deductibles/Co-Ins are due at the time of the service. Not all services are covered by every plan.** It is my responsibility as the guarantor/parent/guardian to understand and have knowledge of my insurance plan. **Any service not covered by my plan will be my responsibility**. I am aware if my account is not paid and sent to collections, the patient(s) will be asked to find another provider. The office does ask that I give a 24 hour notice if I need to cancel or reschedule. **No Show will apply to visits that are missed with a $50 fee. Also if you No Show for a Saturday Appointment there will be no more Saturday Appointments scheduled for your child in the future.**

Phone advice and Tele Medicine will have associated charges and if insurance does not cover the patient will be responsible.

I fully understand and I consent to Children's Oasis Pediatrics' use and disclosure of my children(s) Protected Health Information in order to carry out treatment, payment and health care operations. I also fully understand and consent to Children's Oasis Pediatrics' office policy.

Health Information Exchange
I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HEI), or I previously received this information and decline another copy."

In My Absence:
I, being the parent/legal guardian of the above named minor(s), do hereby give permission to the following individual(s) to act on my behalf in authorizing medical care for the above named minor(s) during my absence. I also authorize Children's Oasis Pediatrics to discuss my child(s) care with the following people.

Name	Relationship to child	Phone Number	Date of Birth

_____ _____ _____
Parent/Guardian (print) Signature Date

Phone #: _____