## Information Sharing and Access

I authorize Neighbors Pediatrics to send me important updates via SMS/Text (message and data rates may apply) to the number provided. We will only contact you regarding appointment reminders, medical services, billing, or matters related to medical care. Please note, only one phone number can be listed for text reminders.

☐ Yes ☐ No Phone Number: _____

I authorize Neighbors Pediatrics to leave a voice mail regarding:

☐ All information including appointments, general info, updates, billing, etc. ☐ Appointment information only

If you would like someone other than the patient's parents/legal guardians to receive or access information about their medical care, please select the information that you authorize us to give out for this patient below. Additionally, please list who has permission to receive or access this information.

Parents do not need to be listed in this section unless the child is 16 years or older. South Carolina law states that at age 16, a patient has the right to choose who has access to medical information.

Type of Information:

☐ Results of Lab Tests/X-rays ☐ Appointment Information ☐ Scheduling Appointments ☐ Medical Information ☐ Billing Information ☐ Payments

Authorized Parties to Receive or Access Information:

| Name: | Relationship to Patient | Phone number | Authorized to Bring to an Appt? ☐ Yes ☐ No |
|---|---|---|---|
| Name: | Relationship to Patient | Phone number | Authorized to Bring to an Appt? ☐ Yes ☐ No |
| Name: | Relationship to Patient | Phone number | Authorized to Bring to an Appt? ☐ Yes ☐ No |
| Name: | Relationship to Patient | Phone number | Authorized to Bring to an Appt? ☐ Yes ☐ No |

An Authorization to Release Information Form must be completed for all releases and disclosures not listed in the section below. A Request for Restrictions must be completed in writing to request restrictions for the use of your information. Any Restrictions involving guardianship must have court documentation with specific instructions for medical care.

## Ambulatory Consent to Treatment

I, _____(as patient, parent, guardian, spouse, guarantor, or other responsible party), consent to and authorize medical treatment and diagnostic procedures which may be ordered and/or provided by my doctor and performed at Neighbors Pediatrics/Tribe 513 ambulatory locations.

I understand that this consent for medical treatment, assignment of insurance benefits, and agreement of financial responsibility will be valid for one year from the date of signature and can only be revoked upon written notice.

## HIPAA Notice of Privacy Practices Consent

Tribe513 & Neighbors Pediatrics, Notice of Privacy Practices can be found by following the QR code.

I certify that I have reviewed and/or received a copy upon request of the Tribe513, Neighbors Pediatrics "Notice of Privacy Practices". I understand that uses and disclosures of my personal health information are described in the Notice of Privacy Practices received. Possible disclosures include, but are not limited to, disclosure to another health care provider or Health Information Exchanges (HIE) for treatment, process of payment, or Tribe513 & Neighbors Pediatrics operations. See attached Notice of Privacy Practices for additional possible disclosures and instructions on how to limit my participation in HIE or to whom my health information is disclosed.

I understand that this consent for medical treatment, including all routine testing, assignment of insurance benefits, and agreement of financial responsibility will be valid for one year from the date of signature and can only be revoked upon written notice.

I understand that the authorization for release of information, which is a separate form I will complete, will be valid for one year from the date of acceptance and can only be modified or revoked upon written notice.

I certify that I have read or have had read to me this consent and agree to its terms. I also certify that I am the patient, or am duly authorized by the patient, or am duly appointed to sign this agreement. I accept and understand its terms.

To the best of my knowledge, the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep this Practice and my Physician informated of changes to any of my contact information.

| Print Patient's Name | Patient's Signature (if 16 years or older) | Phone Number: |
|---|---|---|
| Print Legal Guardian Name: | Legal Guardian Signature: | Today's Date: |

Only the biological parent, legal guardian, or patient can consent to medical treatment and sign this documentation.

| Responsible Party | | | |
|---|---|---|---|
| Patient Last Name | Patient First Name: | Patient Middle Initial: | Patient Date of Birth: |

The Responsible Party is the person who is FINANCIALLY responsible for any balance on the patient's account not covered by insurance. This person will receive all account statements to their address. You CANNOT delegate another person to be the responsible party. If you are 18 or older, you are your own responsible party.

The following section can only be completed and signed by the Responsible Party.

Waiver of Liability: I understand that the treatment/service from the providers and physicians at Tribe513 and Neighbors Pediatrics for the patient listed above may not be a covered treatment/service or may not be covered at 100%. I agree to be personally and fully responsible for any balance due.

Payment Policy: Tribe513 and Neighbors Pediatrics are committed to providing the best treatment for our patients. Our pricing structures are representative of the usual and customary charges for our area.

Responsible Party Acknowledgement: I understand that I am the responsible party for the patient listed above and agree to the terms of the Waiver of Liability and Payment Policy. I have been given a copy for review and I am aware of the availability of these documents in the office at a Tribe513 entity and online at www.tribe513.org. By signing, I agree to adhere to the requirements outlined in the policies provided for the above patient at Tribe513 entities, including Neighbors Pediatrics.

| Responsible Party Full Name: | Relationship to Patient: | Responsible Party Date of Birth: | |
|---|---|---|---|
| Street Address: | City: | State: | Zip Code: |
| Phone Number: | E-mail: | | |
| Responsible Party Signature: | Date: | | |

**Guardianship Statement:**

Only the patient, biological parent, or legal guardian may provide or change demographic information. If you are not the biological parent(s), please provide a copy of the required legal documentation describing guardianship.