Northwest Pediatric Clinic

DELEGATION OF CONSENT FORM

Patient's Name:	
Patient's Date of Birth:	
Parent (establish relationship)/ Legal Guardian's Name Address, and phone number:	

Statement of Medical Treatment (s)/Procedure (s) to be given and purpose of treatment.
Additional pages may be added if necessary to describe specified medical procedure (s); it must be signed and dated by parent/conservator/legal guardian. Initial to consent for the following treatments.

Initial Below

_____ Routine pediatric well care including immunization (s)

_____ Medical evaluation and management of pediatric outpatient illnesses including chronic and/or acute diseases.

_____ Minor in-office procedures

Treating Physician (also include the physicians and advanced practice providers partnered with the treating physician):	

Northwest Pediatric Clinic

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I/We as the parent (s), conservators, or legal guardian (s) of the minor child named above hereby appoint the individuals listed below in order of appearance to act on my/our behalf to consent to the above specified medical treatment(s)/procedures(s) when I/we am/are reasonably unavailable to grant such consent. If I were to choose to terminate this delegation of consent, I must contact Northwest Pediatric practice.

Name of Individual	Relation to Patient (minor child)	Contact Information

Initial Below

_____ I/We understand that if in the event that I/we am/are unavailable to grant consent on behalf of my minor child, the consent of the individual identified above, who I/we have granted authority to consent on behalf of my minor child too, will be considered sufficient for the specified medical treatment(s)/procedure(s) above.

_____ I/We will indemnify and hold harmless, from any expense or claim of any nature, any entity that provides or causes to be provided examination, treatment, or hospital care under this delegation of consent. I understand that I am responsible for payment of all charges that result from care provided by Northwest Pediatric Clinic, including amounts not covered by my insurance pr ovided.

By signing below, I acknowledge that I have read, understand, and agree to this Delegation of Consent.

Parent/Conservator/Legal Guardian: _____ Date:

Parent/Conservator/Legal Guardian: _____ Date:

Witness (Sign & Print Name): _____ Date:

(If document signed by parent/conservator/legal guardian at practice, a witness must sign)

Northwest Pediatric Clinic

General Consent for Treatment

I have voluntarily presented for medical care and consent to such medical care and treatment including any diagnostic procedures and tests that the physician(s), his or her associates, assistants and other healthcare providers determine to be necessary, in the course of the treatment. I understand and acknowledge that no warranty or guaranty has been or will be made as to the result or cure of treatment.

I consent to the taking of photographs or films related to the care and treatment and understand that such photographs or films may be made part of the medical record and/or used for internal purposes, such as performance improvements or education.

I have the legal right to consent to medical treatment because I am the patient, or I am the parent/guardian/ of the patient. All references to "patient", "me" and "my" in this document means: _____ (name of patient).

Electronic Medical Record

We share medical records electronically with other health care providers to allow and promote continuity of care among providers. If you visit another provider who also participates in an electronic medical record system, they may have access to your medical record.

Electronic Prescriptions (E-Prescribing)

I voluntarily authorize E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispensing history as long as a physician/patient relationship exist.

Testing in Event of Healthcare Worker Exposure

I understand that in the event that a healthcare worker is accidentally exposed to the patient's blood or bodily fluids, or AIDS, pursuant to Texas law, I will be required to have blood tested to determine the presence of Hepatitis B or C surface antigen and/or Human Immunodeficiency Syndrome (HIV) antibodies. I understand that these tests are performed by withdrawing a small amount of blood and using substances to test the blood.

I acknowledge that these tests may, in some instances, indicate that a person has been exposed to these viruses when the person has not (false positive) or may fail to detect that a person has been exposed to these viruses when the person actually has been exposed (false negative). I understand that if any is positive, I will receive counseling about the meaning of these tests as it relates to the herein-named patient's healthcare.

I understand that these results will be kept confidential to the extent allowed by law and that unauthorized distribution of these results is a criminal offense under state law.

Acknowledgements

I acknowledge that administrative data, demographic information and other health information describing patient care, services, and outcomes are collected and used for healthcare operations, governmental and non-governmental reporting, and comparisons with other providers. In some instances, performance data is aggregated and reported per physician. In every instance, we make every reasonable effort to maintain physician anonymity.

Advance Directive

The patient has an advance directive: Yes No

If yes, check all that apply: Directive to Physicians: ☐ Medical Power of Attorney: ☐ Out of Hospital DNR: ☐

Please communicate the existence of any advance directive to your health care provider and provide copies for the medical record.

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Patient Name: _____

Patient's Date of Birth (MM/DD/YYYY): _____

Name of Patient's Representative, if patient is under 18 (printed):

_____

Relationship of Patient's Representative, if patient is under 18:

_____

Signature of Patient or Patient's Representative: _____

Date: _____

Signature of witness/translator: _____

Northwest Pediatric Clinic

Policies and Procedures

Thank you for choosing Northwest Pediatric Clinic for your children's needs. At Northwest Pediatric Clinic we pride ourselves on providing quality healthcare and easy accessibility. We welcome you to our practice.

The clinic sees patients by appointments. We recognize that at times, patients will have urgent needs. We will do our best to provide care for your child during those times, but we encourage all patients to phone the office for a scheduled appointment time. This will allow us to provide care in a timely manner for you & your child (ren).

We ask that if you make an appointment you arrive on time, this will help us avoid delays and provide care in a timely manner. We give a grace period of fifteen (15) minutes from your appointment time as a courtesy. Meaning you may be asked to reschedule if time does not permit us to accommodate your appointment past the scheduled time. We do not work-in Well Child (checkup) appointments as those are more complex appointments so if you are not able to keep your scheduled time you will be asked to reschedule for another available day or time.

If you make an appointment but are not able to keep it, please notify us at least 1 hour (60 minutes) prior to your scheduled appointment time. If you fail to do so, it will be considered a "NO SHOW". We only allow three (3) "no shows". After that we will notify you and your insurance company in writing of your child's disenrollment. This policy's purpose is to decrease the number of missed appointments and allow us to better serve our patients with available appointments.

At Northwest Pediatric Clinic, we want to provide you with a clean and friendly environment. We ask that you do not eat or drink in the clinic. We also want to keep a wholesome environment for the children. In order to achieve this, we ask that noise level be kept to a minimum and no harsh words or profanity be used in the clinic.

Thank you for your cooperation and WELCOME to our practice!!!

Signature: _____

Date: _____

Northwest Pediatric Clinic

Consent & Financial Responsibility

I consent to services, treatment, and diagnostics procedures, including medications, lab tests, and other studies which may be ordered by my physician and consultants as selected by my provider at Northwest Pediatric Clinic.

I acknowledge full responsibility for the payment of such services and agree to pay my bill in full **AT THE TIME OF SERVICE** unless other arrangements are made with the finance department. By signing this I assign all rights, title, interest and authorize direct payment to Northwest Pediatric Clinic of any insurance benefits under the Social Security Act for the services. Northwest Pediatric Clinic will assist in billing my insurance company, but I am financially responsible for charges not collected by this assignment, I authorize Northwest Pediatric Clinic to bill my insurance or third-party payer and receive payment from them directly.

I acknowledge that to the extent necessary to determine liability for payment or obtain reimbursement, Northwest Pediatric Clinic may disclose my record to any person, social security administration, insurance, benefit payer which is or may be or may be liable for all or any of the charges.

I have reviewed the posted Notice of Privacy Practices, which explains how medical information may be used & disclosed. I understand that I am entitled to receive a copy of this document if so desired.

My signature acknowledges that I have been given the right to ask questions and receive information about the services and privacy practices. I voluntarily sign this consent, A photocopy and/or faxed copy of this authorization shall be deemed as valid as the original.

Signature of Patient/Parent/Guardian: _____

If Patient is a minor, please state your relationship to patient: _____

Date: _____