



Patient Name: _____

Date of Birth: _____

█ ID: _____

Privacy Practices / Patient Agreement Consent - CHILD

Notice of Privacy Practices Acknowledgement:

I hereby acknowledge that I have been offered or received the █ Notice of Privacy Practices. (For Notice of Privacy Practice, see www.uofmhealth.org/protecting-your-privacy-hipaa)

Agreements:

1. Assignment of Medical Benefits

Except as barred by any agreement between my insurance company and █ or by state or federal law, I understand that I will be responsible for my child’s co-payments, deductibles or other charges for medical services not covered or paid by insurance or other third party payers. I assign all rights and benefits to █ in order to facilitate reimbursement for health care services. I will help █ follow up on these claims. I further understand and agree that █ may reach out to other █ offices, including the Office of Financial Aid, to verify my child’s ability or inability to pay costs not covered or paid by insurance or other third party payers.

2. General Consent to Receive Health Care Services

I agree for my child to receive health care services such as medical, psychological, nursing and/or other health care, which may include procedures, tests, drugs, and treatment necessary to my child’s care. I understand that the █ provides a continuum of care and therefore may contact other healthcare providers and services with the minimum necessary information to facilitate my child’s ongoing care, including but not limited to █ staff and other █ healthcare providers, such as those in █ if there is a clinical need to know and/or urgent situation. I understand that my child may receive care through telehealth services. The limitations of telehealth visits include the possibility of not being able to pick up conditions found during a complete physician exam. There may also be technical difficulties like a lost connection or interruption. I know that my signature provides consent for █ to share this information as needed and provides permission for these services to contact my child once the physician writes an order. I know that I have a right to consent to or refuse to consent to any future care for my child and to discuss this care. The health care provider will discuss with my child either in person or on line, specific care and/or interventions including procedures, and obtain a specific consent. Invasive procedures and special treatments, such as immunizations, may require additional consents. I know that the practice of medicine is not an exact science and outcomes may be different for each patient.

*** By signing below, I agree that I have read and fully understand the content of this consent form.**

Signature of Parent / Legal Guardian

_____/_____/_____
Date

Printed Name of Parent / Legal Guardian

_____/_____/_____
Date

Relationship: Parent Legal Guardian

For █ Use Only: Obtained by: _____ Role: _____

Verbal Consent: Call to: _____ Date & time: _____ Result: _____

█	Form Number: █	Ver: A/2014 Rev: 2/2019	Original – Med Record	Title: Privacy Practice / Patient Agreement Consent
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