FLORIDA PEDIATRIC ASSOCIATES, LLC

AUTHORIZATION AND CONSENT FOR TREATMENT

PLEASE REVIEW CAREFULLY AND ASK STAFF TO EXPLAIN TERMS THAT ARE UNFAMILIAR OR CONFUSING.
THEN, INITIAL APPLICABLE CONSENTS AND SIGN AT BOTTOM OF FORM

_____General Consent for Treatment

I consent for the medical care and treatment that includes a routine medical examination, diagnostic testing, immunizations (when indicated and provided by this office) and other medical services deemed necessary or advisable in the judgment of the physician or other practitioners providing care. I understand that certain aspects of care may be offered at a facility owned by the practice or treating physician, and if so, this information will be disclosed and alternative facilities identified. I understand that health care professional students may participate in my care under the supervision of an attending physician or other health care professional. I am aware that the practice of medicine (including surgery) is not an exact science and I acknowledge that neither the provider nor office staff has made any guarantee or assurance as to the results that may be obtained. I understand that the practice may refuse to provide care if I refuse to sign this consent or if, at any time, I choose to revoke this consent.

_____Consent for 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 exists.

_____Consent for Identification Photograph *(applicable only if this office is using an electronic medical record).*

I consent to a patient photograph that will only be used for identification purposes and will be securely stored. Medical care will not be affected if I refuse to provide consent or withdraw my consent in the future.

_____Consent to Call

I understand and agree that the practice may need to contact me regarding appointments, preventative care, test results, treatment recommendations, outstanding balances, or any other communications from the medical group. These communications may include automated calls, emails, and text messaging sent to my landline and/or mobile device. I understand that I must voluntarily "opt-in" to receive automated text message communications from the practice and agreeing to additional Terms and Conditions as set forth by my mobile carrier.

_____Consent Testing in the Event of Healthcare Worker Exposure

I understand that in the event that a healthcare worker is accidentally exposed to a patient's blood or bodily fluids, the patient will be required to undergo a blood test 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 and testing a small amount of the patient's 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). If any test is positive, the practice will provide counseling about the meaning of these tests as it relates to patient healthcare. I understand that these test results will be kept confidential to the extent allowed by law and that unauthorized distribution of these test results is a criminal offense under state law.

The undersigned certifies that he/she read and understand this document and has the legal right and is duly authorized to provide consent for the initialed provisions as the patient or the parent or legal guardian of the patient.

Patient (print name): _____

Signature of patient or authorized person: _____

Relationship: _____ Date: _____