Patient Name / DOB:_____ **Patient Name / DOB:**_____

Notice of privacy policy and Financial Policy: Please find a copy of our **HIPAA** (Health Insurance Portability and Accountability) (Privacy Policy Act) and the **Financial Policy** with the **Credit Card On File policy** on our website WWW. PARTNERS4KIDS.COM or **scan the QR code** on the corner of this registration form.

Credit Card on File

Patient / parent / guardian reviewed a copy of Partners 4Kids' Financial and Credit Card on File Policies. Patient / parent / guardian agree to provide their credit card information for the sole purpose of payment for patient's medical care. Patient / parent / guardian have the right to cancel this process and use another form of payment.

___ I read and understood the CCOF policy. I agree to add my credit card on file. Yes ____ No ____

Consent to treatment: Patient / parent / guardian signing this document gives their permission to the health care providers of Partners 4Kids and such assistants as they may consider necessary to supply medical services to patient. Patient / parent / guardian understand by signing this form and authorizing Partners 4Kids to treat the patients for as long as they seek care from Partners 4Kids providers, or until they withdraw the consent in writing.

Consent for electronic communication

Patient / parent / guardian signing this document gives consent to have Partners 4Kids to communicate with them by any electronic methods referring to any aspects of my child(ren)'s medical care and treatment: (test results, prescriptions, appointments, billing, etc.). I understand that any electronic communication is not a secure method of communication. Patient / parent / guardians understand that in an urgent situation to not rely on electronic communication.

Photo/Video/Media Consent: Patient / parent / guardian consent to the taking and use of photographs/ videos of the patient by Partners 4Kids. Usage includes but is not limited to our website, all social media platforms, advertisements and in our office. Please note, this waiver will be in effect until you provide, in writing, with a cease order. **Yes _____ No** ____

Telemedicine appointment: If you request a telemedicine appointment, before the appointment, you must complete a consent form our website, WWW. PARTNERS4KIDS.COM

No Show Policy: Every appointment scheduled by any patient / parent / guardian will be responsible to attend, cancel or reschedule the appointment. If the patient is unable to attend any scheduled appointment, the patient / parent / guardian will call, leave a voicemail. send a portal message, send an email info@partners4kids.com, or respond "NO" to the reminder text message. If the patient does not attend the appointment, cancel or rescheduled, Partners 4Kids has the right to charge me $50.00 for a no-show fee.

By signing this document patient / parent / guardian agree to understand everything mentioned above. Patient / parent / guardian have read/received the Notice of Privacy Policies HIPPA https://partners4kids.com/Patient-Info/Office-Policies and Financial Policy **https://partners4kids.com/Patient-Info/Office-Policies**

Print Name: _____Relation to patient: _____Phone#:_____

Signature: _____Date: _____

Medical consent for minors(s) – if a parent or legal guardian is not the presenter of child(ren)
I, _____ parent or legal guardian of _____ do herby consent to any medical care/procedures and the administration of medications/ vaccinations/ screenings/ procedures decided by a physician to be necessary for the welfare of my child(ren) while under the care of:

Temporary Guardian 1:	**Phone #:**	**Relationship:**
Temporary Guardian 2:	**Phone #:**	**Relationship:**