VIP PEDIATRICS, PA

WRITTEN ACKNOWLEDGEMENT OF RECIEPT OF VIP PEDIATRICS NOTICE OF PRIVACY PRACTICES, CONSENT TO TREAT, & ADVANCED DIRECTIVES

General Consent to Treat

I am the parent/guardian of _____ (name of patient). I have the legal right to consent to medical and surgical treatment for this patient.

I voluntarily authorize and consent to such medical care, treatment, and diagnostic tests that Dr. Wolens and his designated associates or assistants believe are necessary for this child. Additionally, I understand that services may be rendered by an advanced practice nurse. An advanced practice nurse is not a doctor. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advanced practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advanced practice nurse may treat minor lacerations and other minor injuries.

I understand that by signing this form, I am giving permission to the doctors, physician assistants, advanced practice nurses, nurses, and other health care providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent. I understand that at any time I can refuse to see the advanced practice nurse or physician assistant and request to see a physician.

I voluntarily authorize and consent to the exchange of medical data including medications, consults, vaccinations, diagnostic tests, and hospital records.

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.

Advanced Directives

In Texas, there are three types of Advanced Directives. Please check all boxes for forms that you have already completed and provide copies of these forms for VIP PEDIATRICS to place in child=s medical record. Please leave area blank if this does not pertain to the patient.

1. _____ Directive to Physicians 2. _____ Medical Power of Attorney
3. _____ Out-of-Hospital Do Not Resuscitate Order (DNR).

Authorization for Specific Communication (Please check the appropriate boxes)

_____ I authorize VIP PEDIATRICS to leave general medical information messages for this patient on telephone voice mail systems for numbers I have provided.

_____ I authorize VIP PEDIATRICS to communicate (non-urgent issues only) via email.

Notice of Privacy Practices

By signing below, you acknowledge receiving the VIP PEDIATRICS Notice of Privacy Practices (Notice). The Notice explains how VIP PEDIATRICS may use and disclose your protected health information for treatment, payment, and health care operations purposes.

Protected health information means your personal health information found in your medical and billing records.

Your signature below acknowledges that your consent of treatment for the patient by a doctor or nurse practitioner, authorization to the above checked communications, and receipt of the Notice.

If you have questions about the Notice, please contact VIP PEDIATRICS. Contact information is located in the Notice.

Name of Patient: _____

Print Name of Patient=s Representative _____

Relationship of Patient=s Representative to Patient: _____

Signature of Patient or Patient=s Representative: _____

Date: _____ Updated 7/2019