Patient Name:_____ **Date of Birth**_____

Consent to Treat/Acknowledgement of Notice of Privacy Practices
Beyond Care Pediatrics, LLC
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Beyond Care Pediatrics, LLC** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Beyond Care Pediatrics, LLC** describes such uses and disclosures more completely.)

Patient Rights: I have the right to review the Notice of Privacy Practices prior to signing this consent. **Beyond Care Pediatrics, LLC** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Beyond Care Pediatrics, LLC
16945 Frances St, Ste 200 B
Omaha, NE 68130

PATIENT RESPONSIBILTY: With this consent, **Beyond Care Pediatrics, LLC** I understand that I am financially responsible to **Beyond Care Pediatrics, LLC** as a patient for all charges not covered by your insurance company. Including Copay, deductibles and other out of pocket expenses.

PATIENT NOTIFICATION: With this consent, **Beyond Care Pediatrics, LLC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

PATIENT NOTIFICATION: With this consent, **Beyond Care Pediatrics, LLC** may e-mail to the email I provide or other alternative location any items that assist the practice in carrying out TPO, such as portal links, appointment reminders and sttaements. I have the right to request that **Beyond Care Pediatrics, LLC** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Beyond Care Pediatrics, LLC** to use and disclose my PHI to carry out TPO, I consent to allow them to bill my insurance and provide any necessary documentation.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Beyond Care Pediatrics, LLC** may decline to provide treatment to me.

PERSONAL VALUABLES: This facility shall not be liable for my loss of damage of personal property.

I have received or been offered a copy of the **Beyond Care Pediatrics, LLC** Notice of Privacy.

Initial here: _____

Please sign below giving us consent to treat you today.

_____ _____ _____
***Signature* of Patient or Legal Guardian** **Relationship to Patient** **Date**

_____
***Print Name* of Patient or Legal Guardian**

Consent valid for 365 days.