



General Consent for Care and Treatment
Must be filled out by patient if 14 years of age and older

Child's Name: _____ Date of Birth: ___ / ___ / _____
Parent/Legal Guardian's Name(s): _____

Consent for the administration and release of immunizations to be put on Imprint, the state registry.

Consent to authorize the physician and her associates to use or disclose personal health information to provide medical or minor surgical treatment, including but not limited to diagnostic procedures, x-rays, and medication.

I authorize HEALS, Inc. to release to any third-party payer, or its representatives, which may be responsible for payment of my treatment.

I hereby assign payment directly to HEALS, Inc. of the insurance benefits otherwise payable to me but not to exceed the balance due to HEALS, Inc.

If my child is not covered under Medicaid or ALL-Kids, I assume full financial responsibility for payment of all services provided to my child, including any portion of my bill that is not paid by my insurance company. I have read and understand the financial policy.

I understand that any health-related papers that are given to me by HEALS, Inc. is my responsibility to maintain confidentiality and keep the protected health information secured.

Consent for my child's treatment in my absence will be on file in my child's chart and updated every 2 years. You may update this at any time by asking the receptionist to update your child's enrollment status.

HEALS, Inc. has the right to use and disclose your PHI for all activities that are included within the definitions of "treatment", "payment" and "health care options" as defined in the HIPPA privacy rule.

HEALS, Inc. may disclose your PHI to any physician or other health care provider involved with the medical services provided to you. This includes disclosure of your PHI to other healthcare providers through electronic exchanges such as patient registries and Health Information Exchanges.

I understand that this consent form covers multiple authorizations and therefore this consent shall carry in effect from the date of my signature until I terminate this agreement in writing or when it is updated by staff on a yearly basis.

Any physician, staff, employee, or representative of HEALS, Inc. has my permission to discuss and / or disclose information regarding medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information to facilitate and coordinate my care and treatment with the following persons:

Contact Name: _____ Relationship to the patient: _____
Phone number: _____

Contact Name: _____ Relationship to the patient: _____
Phone number: _____

Consent to call: YES NO

Consent to text: YES NO

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature: _____ Date: _____

Must be signed by patient if 14 years of age and older