GENERAL CONSENT FOR TREATMENT, FINANCIAL AGREEMENT, & RELEASE FORM

PATIENT LEGAL FULL NAME: _____DATE OF BIRTH: ___/___/___

LEGAL GUARDIAN FULL NAME: _____RELATIONSHIP: _____

CONSENT TO TREAT: I, legal adult patient or the legal guardian, consent for myself or the patient listed above (the "Patient") to receive medical care, testing and treatment by Coastal Kids & Pediatric Associates Family of Companies (the "Practice") and the providers. This may include medically necessary examinations, treatments, prescribing and giving medications, injections, immunizations, screenings and questionnaires, diagnostic testing, laboratory procedures, in-office procedures, arrangement for healthcare services, emergency services by the provider, other licensed staff members or staff under the supervision of licensed provider for this visit, future visits, and telehealth visits. Patient understands the providers may include physicians, nurse practitioners, physician assistants, and other clinicians as well as students, trainees, and clinicians both employed and not directly employed by the Practice.

Patient understands the right to consent or refuse to consent to any medically necessary treatment or procedure, except as otherwise required by law. Patient understands they have the right to discuss all medical treatments with the providers. Patient understands that the practice of medicine is not an exact science, and that diagnosis and treatment may involve the risk of injury or death. Patient understands that no guarantees have been made regarding diagnosis, treatment or care the Patient may receive. Patient understands that this consent to treatment must be signed, in order, for the Patient to be seen and will be considered valid until such time that the Patient revokes this consent in writing.

CONSENT TO TELEHEALTH: Patient agrees to care and treatment involving the use of electronic communications between the Patient, legal guardian, and provider transmitted by telephone and/or by video or other transmitted information to a provider who is at a different place than the Patient. Telehealth services allows healthcare providers at remote locations to share the Patient's medical information for diagnosis, therapy, follow-up, and education purposes. Patient gives consent and authorizes the Practice and the providers to forward the Patient's information to a third party as needed to receive telehealth services, and Patient understands that existing confidentiality protections apply.

Patient understands that while telehealth services can be used to provide improved access to medical care, as with any medical service or procedure, there are potential risks. These risks include but are not limited to technical problems with the information transmission and equipment failures that could result in lost information or delays in treatment. Patient understands that they have a right to withhold or withdraw their consent to the use of telehealth services during treatment at any time, without affecting the Patient's right to future treatment.

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CONSENT TO MEDICATION HISTORY: Patient authorizes the Practice and providers to request, use, and disclose the Patient's medication prescription history from and to other healthcare providers and/or third-party pharmacies as necessary for treatment purposes.

MEDICAL TEACHING & TRAINING: Patient understands and gives consent to the providers, clinicians, and other health professionals may be involved in training during the Patient's treatment. Patient understands and give consents to the Practice and providers to allow non-employees, such as students and associated health care providers who are participating in educational programs, access to the patient care areas. Patient understands that they may have access to incidental health information. Patient understands they have the right to question the provider regarding such training and can choose not to authorize such access during the Patient's examination and treatment.

MEDICAL IMAGES: Patient authorizes photos may be made of the Patient for the purpose of care or medical teaching. Patient understands these images will be stored in the Patient's medical record in a secure manner that will protect the Patient's privacy. The images will be kept for the time-period as required by law.

RELEASE OF HEALTHCARE INFORMATION: Patient authorizes the Practice to share the Patient's protected health information for treatment and payment purposes with the non-custodial adults listed below when these individuals bring the Patient to his/her visits. Patient understands they have the legal right to preauthorize treatment, and request that the Practice deliver medical treatment when the legal guardian is unable to be present for the Patient's visits and may the legal guardian telephonically. However, I understand that this authorization to treat is not contingent upon their ability to successfully reach myself as the Patient's legal guardian.

USE AND DISCLOSURE OF INFORMATION: Patient consents to the use and disclosure of information from the Patient's medical records, including protected health information, by the Practice for treatment, payment, and health care operations as permitted by law. All uses and disclosures will abide by the terms identified in the Notice of Privacy Practices.

Patient authorizes the Practice to release all immunization records upon request directly to the Patient's educational institute and/or day care facility. Patient understands this authorization will remain in effective until such time the Patient revokes this consent in writing. Patient understands that, in order, to restrict disclosure of immunization records, the Patient must request and complete the Request for Limitation and Disclosure of Protected Health Information Form, which would include the Patient's immunization records to schools.

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT: Patient hereby assigns and authorizes payment of insurance benefits directly to the Practice. Patient understands they are financially responsible for any charges not paid by the insurance company. Patient authorizes the release of Patient's health and financial information to the applicable health insurance payer, including

commercial and governmental payers. All fees not covered by insurance must be paid at the time at which services are rendered. At the time of the visit, the Patient understands the person who brings the Patient to an appointment may be financially responsible.

The Practice may assess fees for missed appointments, returned checks for insufficient funds, and collections activities. Patient acknowledges they are able to access the Missed Appointment Policy on the website.

OFFICE POLICIES: Patient has reviewed any office policies that have been presented, and any questions regarding the policies have been answered to my satisfaction. Patient agrees to comply with the policies.

CONSENT TO ELECTRONIC COMMUNICATION: Patient authorizes the Practice to use Patient's information to send reminders regarding upcoming appointments, to obtain feedback on the practice experience and to provide general health information via e-mail and/or text messaging.

NOTICE OF PRIVACY PRACTICES:

◯ By selecting this section, Patient acknowledges that they have received information on the Notice of Privacy Practices, which sets forth the ways in which health information may be used or disclosed by the Practice and outlines the Patient's rights with respect to such information. Patient understands the Notice is also available on the Practice's website or in the office upon request.

HEALTH INFORMATION EXCHANGE:

◯ By selecting this section, Patient elects to authorize the release of the Patient's health information to the applicable regional California health information exchange, and I understand that the information may be accessed by authorized participating health care providers. I understand that I may revoke this authorization, and that the revocation will become effective on the date it is made and will not apply to health information already released or exchanged.

OTHER LEGAL GUARDIANS:

1. Full Name: _____

   Relationship to Patient: _____

   Phone Number: (_____)_____
2. Full Name: _____

   Relationship to Patient: _____

   Phone Number: (_____)_____

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3. Full Name: _____

   Relationship to Patient: _____

   Phone Number: (_____)_____

OTHER NON-CUSTODIAL ADULTS WHO MAY BRING PATIENT TO VISITS & RECEIVE PATIENT'S HEALTH INFORMATION:

1. Full Name: _____

   Relationship to Patient: _____

   Phone Number: (_____)_____

2. Full Name: _____

   Relationship to Patient: _____

   Phone Number: (_____)_____

3. Full Name: _____

   Relationship to Patient: _____

   Phone Number: (_____)_____

SIGNATURE OF LEGAL GUARDIAN OR PATIENT (IF PATIENT IS 18 YEARS OR OLDER): By my signature below, Patient certifies they have read, understood, and agreed to the terms on this General Consent, Financial Agreement, and Release Form. Patient certifies that information given of the Patient's identity, demographic, financial, and insurance information is truthful. Patient certifies that they were given the opportunity to ask questions and all questions (if any) have been answered to their satisfaction.

_____ _____

Signature of Legal Guardian or Patient (if patient is 18 or older) Date

_____

Printed Full Name of Legal Guardian or Patient