Consent for Treatment/ Acknowledgement of Notice of Privacy (HIPAA)
and Consent to Use/ Disclose Health Information

Being at least 18 years of age and of sound mind, I Patient/Guardian, the undersigned patient/responsible party have been informed of the treatment considered necessary for:

Patient Name: DOB:

and any extension of this treatment or procedure, whether or not currently anticipated, that the attending physician may consider necessary during the course of such procedure in order to correct an immediate medical problem, and that such treatment and procedures (i.e., Labs, Vaccinations) will be performed by physicians who are staff members of **Sunshine Children's Clinic**. The undersigned hereby consents and grants authorization for such treatment and procedures and certifies that no guarantee or assurance has been made as to the results that may be obtained. (The undersigned further consents to the disposal in accordance with applicable laws of body tissue or body parts that may be removed during the course of the procedure.)

The undersigned agrees to pay for the service rendered by **Sunshine Children's Clinic** on the release of the patient.

I do hereby assign any hospital benefits of a liability of and payable by any third party for the herein-named patient to **Sunshine Children's Clinic** unless I pay the full amount on the release of the patient.
I do authorize Health Information Services of **Sunshine Children's Clinic** to release any information requested by my insurance company(s) or other third-party payers in connection with this assignment. I do hereby appoint the Financial Manager of **Sunshine Children's Clinic** as my lawful attorney to endorse for me any checks payable to me for debts or claims collected under this assignment and to apply any credit balance to any other debt Imay owe **Sunshine Children's Clinic**.

Statement of Financial Responsibility
All services rendered are the payment responsibility of the patient. As a courtesy, we will bill your insurance carrier. The patient is responsible for all fees, regardless of insurance coverage or the usual and customary fees provided by your insurance company. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I will be responsible for any costs incurred as a result of my account having to be turned over to a collection agency or attorney.

I understand the full importance of this declaration.

I acknowledge that I have received a copy of **Sunshine Children's Clinic** Notice of Privacy Practices. I understand that as a part of my healthcare, **Sunshine Children's Clinic** originates and maintains health records describing my health history, symptoms, examination, and test results, diagnosis treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A means of which insurance companies can certify that services billed were actually provided
- A source of information for applying my diagnosis and surgical information to my bill
- A tool for routine health care operations, such as assessing quality and reviewing the competence of the healthcare professionals

Before signing this form, you should understand the following:

- I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected
- I authorize the release of any medical other information to process the insurance claim resulting from this service. I also request payment of government benefits either to myself or to the party who accepts assignment below.
- I understand that I have the right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
- I understand that I have the right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. Section 164.524).
- I give consent to Sunshine Children's Clinic to examine and treat my child as deemed necessary by the Provider for the period of 01/01/2021 to 12/31/2021.
- The following parents/guardians are allowed to bring my child to Sunshine Children's Clinic:

Patient, Parent, Guardian, or Representative Signature: Date:

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