Label Placeholder

Wayzata Children's Clinic

General Consent

Consent to Treat

I consent to and authorize the physicians, nurses and other healthcare providers at Wayzata Children's Clinic, P.A. (WCC) to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

WCC is a teaching clinic. In addition to my clinician and other medical support staff, I may receive care from people who are in training. They are supervised by licensed health care providers. I may decline to have these individuals involved in my care and this will not affect my care or treatment.

Assignment of Benefits/Payment for Services

I authorize payment of any and all benefits to WCC. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with WCC to get payment for my care. This includes clearing up any disputes about charges. If I am eligible for payment from more than one type of coverage, WCC will return any extra payments to the payer. If I have an unpaid bill at WCC, any refunds due to me will be put on my unpaid bill. If there is money left over after my bill is paid, I will get a refund from WCC.

Release of Information for Treatment, Payment and Health Care Operations

I consent to and authorize WCC to use and disclose my protected health information for **treatment**, **payment** and **healthcare operation purposes**, including care coordination and quality assessment and improvement activities. Releases for these purposes may be made to consultants who are being advised or consulted in connection with my treatment, insurance companies, health plans, e-prescribing services, record locator services, payer network organizations, including clinically integrated networks and/or accountable care organizations in which my provider participates, and other healthcare providers involved in my care and treatment. Additionally, I consent to and authorize my insurance company to share any of my protected health information for the purposes stated above to WCC and/or a clinically integrated network or accountable care organization in which WCC participates.

Patient Rights and Privacy Practices

You and your family's rights and our privacy practices are posted in main areas within WCC. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider or WCC's Privacy Officer.

Other Third Party Individuals Authorized to Consent to Treatment

In addition to the legal guardians of the patient, the following persons are authorized to consent to the recommended medical care for my child (e.g., Step parent, grandparent, daycare provider, etc.):

Name:	**Relationship to child:**
1._____	_____
2._____	_____

Mobile Phone Consent

Yes, WCC may call my provided mobile phone number about the care, treatment, services and accounts using pre-recorded messages, automatic telephone dialing systems and/or text messages. Standard text message and minute usage rates may apply. I am aware information in a voice or text message may not be secure and that providing this consent is not a condition of receiving treatment.

My signature here means I have read this information and understand it. The consent to treat is valid for one year from the date of signature. All other authorizations contained in this consent are valid until revoked in writing.

Print Patient/Parent/Guardian Name: _____ **Date:** _____

Patient/Parent/Guardian Signature: _____

Relationship to Patient: _____ **Name of Interpreter (if used):** _____

Parent Email Address: _____

Telephone consent obtained by (Name/Date/Title): _____

Frequently Asked Questions (FAQ's)
For Patients on the General Consent Form

Why are you asking me to sign this consent form?
We are required by law to have your written acknowledgement of/permission to:

- Treat you/your child;
- Receive any insurance benefits from your insurance company/health plan due to you for the treatment we provide you/your child;
- Share your/your child's medical information outside our practice. There are different reasons we share your information. We share information with other medical providers who care for you/your child and with your health insurer to get paid for your/your child's care. We also share information to run our practice, improve the quality of your care, coordinate your care with other providers, and make health care more affordable. This consent allows us to share your information for all of those purposes;
- Your receipt of a copy of CLINIC's Notice of Privacy Practices, which explains how CLINIC may use your/your child's health information and what your rights are regarding your/your child's information; and
- Allow anyone other than a legal guardian to bring your child to an appointment and consent to recommended care that may occur at that appointment.

Is my medical information kept secure?
We are required by law to protect the privacy and security of your medical information. We will use and disclose your information only as described in the consent and as permitted by law. To help protect your privacy, when possible, we use information that does not include your name or other identifying information. Please see our Notice of Privacy Practices for more information.

What is an accountable care organization (ACO)?
An accountable care organization is a group of health care providers who work together to improve health care quality and make health care more affordable. Our practice participates in accountable care organizations and shares patient information with them as described in the consent.

What is a payer network organization?
A payer network organization is an organization of health care providers organized by a health plan or other payer to improve health care quality and make health care more affordable. Our practice participates in payer network organizations and shares patient information with them as described in the consent.

What is a clinically integrated network (CIN)?
A clinically integrated network is a network of physicians and other health care providers, often working in collaboration with a hospital, who work together to improve the quality and efficiency of patient care; it is developed and managed by physicians and supported by a performance management infrastructure.

Do I have to sign this consent form?
You do not have to sign this consent form. However, included within this consent form is consent allowing us to treat you/your child, if you do not sign, we are not be able to treat you/your child.

If I cross off portions of this consent that allow for data sharing but sign the form, can my child still be treated?
Yes. In the Release of Information section of the consent form, you may cross off what reasons you do not want your/your child's information to be shared (treatment, payment and/or healthcare operations) or you may cross off what entities your/your child's information may not be shared with (insurance companies,

health plans, government programs, etc.) Keep in mind that this could make it difficult to coordinate your care, delay your care or keep your insurer from paying for your care.

What if I change my mind after I sign the consent?
You have the right to cancel (revoke) this consent. You may do so by sending us a written request to cancel it. If you cancel your consent, the cancellation will apply going forward from the date we receive your request. Any releases of your/your child's information that happened before you cancelled the consent will not be changed.