CERTIFICATE OF AGREEMENT

1. **CONSENT TO MEDICAL TREATMENT:** The undersigned consents to medical treatment which may be performed during care provided by the practice on an outpatient basis, including office visits, well examinations, emergency treatment, procedures and/or services, immunizations, injections, minimal laboratory procedures and general health screenings.

   (Initial Here) _____

2. **FINANCIAL AGREEMENT:** The undersigned agrees to the financial policies of the practice, whether he/she signs as the parent/legal guardian or as the patient, in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the practice in accordance with the regular rates and terms of the practice. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

   (Initial Here) _____

3. **ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS:** The undersigned authorizes, whether he/she signs as a parent/legal guardian or as the patient, direct payment to Children's Hospital of Orange County, physicians. It is agreed that payment(s) to the above, pursuant to this authorization, by an insurance company or health plan, shall discharge said insurance company or health plan of any and all obligations under a policy or contract to the extent of such payment(s). It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

   a. **AMBULATORY HEALTH CARE SERVICES:** It is understood that all parts of this agreement will remain in effect until terminated in writing by the undersigned, or until consent is signed at a later date, *or three year from the execution of this consent, whichever occurs first.* It is further understood that a copy of this assignment shall be valid as the original. Further, the undersigned understands that the practice is under no obligation to provide coordination of benefits services to the undersigned. Therefore, the practice will not be responsible for reviewing, determining or coordinating services provided such that the service plan coverage is maximized.

   (Initial Here) _____

4. **NOTICE OF PRIVACY:** The undersigned acknowledges their rights under the Notice of Privacy Policy and consents for the practice to use and disclose protected healthcare information for the purpose of treatment, payment and healthcare operations as described in the Privacy Policy, whether he/she signs as a parent/legal guardian or as the patient.

   (Initial Here) _____

CERTIFICATE OF AGREEMENT

5. **CAREGIVER AUTHORIZATION:** The undersigned gives authorization to the qualified relatives and/or caregivers to see care which include immunizations, physical exams, testing and/or treatment for the purpose of medical diagnosis and medical care, which is deemed advisable and is to be rendered by the providers and staff of the practice, whether he/she signs as the parent/legal guardian or as the patient.

   (Initial Here) _____

6. **HEALTH CARE SERVICE PLAN OBLIGATION:** The practice maintains a list of health care service plans with which it has contracted. A list of such plans is available upon request from the Business Office. The undersigned understands that if his/her health care service plan has a contract with this practice, the patient's plan will be financially responsible, subject to co-payments, deductibles or other limitations, for full cost of those services covered by the plan. The practice has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full cost of all services rendered to him/her by the practice if he/she belongs to a plan which does not appear on the above mentioned list, or, in the case of a plan which does appear on the list, if the services are not covered by the plan.

   (Initial Here) _____

7. **RELEASE OF INFORMATION:** Upon inquiry, the practice may make available to the public or purchased service partner certain basic information about the patient's general condition. Such release of basic information to the public or shared service partner does not apply to patients of psychiatric, psychological, alcohol or drug abuse programs. If the patient or the patient's legal representative does not want such information to be released, he/she must specify such requests in writing. The practice will obtain the patient's or patient's legal representative's consent and his/her written authorization to release information, other than basic information, concerning the patient, except in those circumstances when the practice is permitted or required by law to release information. The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the practice may disclose portions of the patient's record, including his/her medical records, to any person, agency or corporation which is or may be liable, for all or any portion of the charges, including but not limited to insurance companies, health care service plans, or worker's compensation carriers. Special permission is needed to release this information where the patient is being treated for alcohol or drug abuse, psychological or psychiatric reasons.

   (Initial Here) _____

CERTIFICATE OF AGREEMENT

8. **CONSENT TO PHOTOGRAPH:** I consent to the taking of photographs, videotapes, digital or other images of my medical or surgical condition or treatment, and the use of the images, for purposes of my diagnosis or treatment or for practice operations, including peer review and education or training programs conducted by the practice. These photographs will not be shared outside of office personnel and only for the purposes mentioned herein. I also understand that photographs, videotapes, digital or other images may not be taken while in the office without the consent of the provider/staff.

   ☐ **I DO NOT consent/agree to my child being photographed.**

   (Initial Here) _____

9. **PERSONAL VALUABLES:** The undersigned understands that the practice does not maintain facilities for the safekeeping of money and valuables and agrees that the practice shall not be liable for the loss or damage to any money, jewelry, clothing, documents, or other personal property brought into the office. The practice reserves the right to prohibit personal items, including electrical appliances, which the practice determines may constitute a safety hazard, a disturbance to other patients, or an impediment to patient care. Firearms, illicit drugs, and/or weapons are prohibited.

   (Initial Here) _____

10. **TELEPHONE CONSUMER PROTECTION ACT:** By providing us with a telephone number for a land line, cellular or other wireless device, you agree that, in order for us or our service providers to service your account(s) (including contacting you about appointment reminders, obtaining potential financial assistance for your account(s)) or to collect any amounts you may owe, we, our agents, representatives, or other service providers may contact you at the telephone number(s) indicated on the Patient Information Form. You expressly consent that methods of contact may include using telephone calls, text messaging, pre-recorded and artificial voice messages and/or the use of an automatic dialing device, as applicable. This consent applies to all services and billing associated with the patient, parent/legal guardian.

    ☐ **I DO NOT consent to the use of pre-recorded messages, text messages, and artificial voice messages and/or the use of automatic dialing device, as applicable.**

    (Initial Here) _____

11. **CONSENT FOR ELECTRONIC MAIL ("EMAIL") USE:** Email communications should be between the practice and an adult patient 18 years of age or older, or the parent, guardian or legal representative of a minor. Email should only be used for non-sensitive and non-urgent issues. Email Communications are appropriate for the following type of transactions; appointment scheduling / reminders, billing questions, patient experience surveys, prescriptions / refills, general medical advice after an initital face-to-face visit, referrals, and lab/test results.

    (Initial Here) _____

CERTIFICATE OF AGREEMENT

12. **CHILD PASSENGER SAFETY:** The State of California requires that children under age 8 must be properly buckled into a car seat or booster in the back seat (Vehicle Code 27360). Children age 8 or older may use the vehicle seat belt if it fits properly with the lap belt low on the hips, touching the upper thighs, and the shoulder belt crossing the center of the chest. Children under 2 years old must be rear-facing (facing backward) in a car seat, unless they weigh 40 pounds or more or are 40 inches tall or more. If children are not tall enough for proper belt fit, they must ride in a booster or car seat (Vehicle Code 27360.5).

    ☐ **I have received information regarding Child Passenger Safety.**

    (Initial Here) _____

13. **PORTAL USE:** By agreeing to the use of our online portal, parents/legal guardians may communicate with the practice/provider for the purpose of updating demographics, requesting appointments, accessing patient records, lab results and online bill pay. The portal will not be available for use between the ages of 12 to 17 years. Once the patient turns 18 years of age, he patient may again have access to the portal for communication purposes.

    (Initial Here) _____

14. **TERMS OF AGREEMENT:** It is understood that all parts of this agreement will remain in effect until terminated in writing by the undersigned, or until another agreement is signed at a later date, *or one year from the execution of this agreement, whichever occurs first.*

The undersigned certifies that he/she has read the foregoing, received a copy thereof and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

This Consent of Agreement/Consent to treat shall bind the parties hereto, including newborns, and the heirs, representatives, executors, administrators, successors, and assigns of such parties and newborns.

_____ _____
Patient/Parent/Guardian/Legal Representative Date Time

_____
If signed by other than patient, indicate relationship

_____ _____
Witness Date Time