SOUTHDALE PEDIATRIC ASSOCIATES, LTD.
Consent for Services

Patient Name_____ **Date of Birth_____**

AUTHORIZATION FOR TREATMENT:
I authorize Southdale Pediatric Associates, Ltd. to provide treatment to myself or the above named patient.

NOTICE OF PRIVACY PRACTICES:
I have been given a copy of Southdale Pediatric Associates, Ltd. Privacy Practices in compliance with HIPAA legislation.

ASSIGNMENT OF BENEFITS:
I authorize my insurance company to pay and hereby assign directly to Southdale Pediatric Associates, Ltd, all benefits, if any, otherwise payable to me for services. This authorization may be revoked by either me or my insurance company at any time in writing.

REFERENCE LABORATORY SERVICES:
I understand that Southdale Pediatric Associates, Ltd. utilizes the services of an outside lab to perform some of the lab tests requested by its physicians. I further understand that the Reference Laboratory will bill separately for its services. I consent to Southdale Pediatrics providing demographic information as necessary for billing purposes.

CANCELLATION OF APPOINTMENTS
I understand that I must give a 24 hour notice to cancel my appointment. I further understand that future services may be denied if I fail to keep my scheduled appointments.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:
I authorize release of copies of pertinent medical records to providers outside of Southdale Pediatric Associates, Ltd. who are being consulted with and/or I am being referred to in connection with my current treatment, to insurance companies for the purpose of determining benefits for services provided, and to reference laboratories for billing purposes.

AUTHORIZATION FOR RELEASE FOR RESEARCH OR QUALITY IMPROVEMENT:
Minnesota Law requires us to inform you that a copy of your medical record, no matter when created, may be released to outside groups for medical research or quality improvement purposes unless you object. Researchers cannot use patient names or identifying characteristics when reporting any results of their research. We evaluate these requests to ensure that the release of patient records is necessary to accomplish the research purpose.

PAYMENT AGREEMENT/COLLECTION POLICY:
I, the undersigned, do hereby expressly guarantee payment of all charges for medical services rendered, or to be rendered by Southdale Pediatric Associates, Ltd. I understand that it is my responsibility to provide Southdale Pediatrics with current insurance information. I understand that a finance charge of 8 % per annum is charged to any balance 60 days or older on my account. I will be responsible for the balance due, plus any costs that are incurred by Southdale Pediatric Associates, Ltd., in collecting my account.

NON VIOLENCE POLICY
I understand that Southdale Pediatric Associates is committed to providing its employees with a safe, nonviolent workplace and reserve the right to determine whether particular conduct violates this policy or is otherwise inappropriate.

AUTHORIZATION FOR REVIEW OF PRESCRIPTION HISTORY
I authorize Southdale Pediatric Associates, Ltd. to access my electronic records of previously prescribed medications through the external electronic prescribing network, Surescripts.

USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION
●My insurer may share my past, current and future health and account records with Southdale Pediatric Associates, Ltd. about services I've received from Southdale Pediatric Associates, Ltd. and other care providers unrelated to Southdale Pediatric Associates, Ltd. These records may be used by Southdale Pediatric Associates, Ltd. as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

●_____My insurer **MAY NOT RELEASE** any of my identifiable health records from providers unrelated to Southdale Pediatric Associates, Ltd. for the purposes described above.

By signing this form, I am consenting to treatment and agreeing to these policies. I understand this authorization will remain in effect until I revoke it in writing.

_____	_____	_____
Date	Signature Patient (if 18 yr.) / Parent / Legal Guardian	Relationship to Patient