Hometown Pediatric Care

Patient Name:_____

DOB:_____/_____/_____

ANNUAL GENERAL CONSENT-2024

Consent for Medical Treatment:
I and/or my parent(s) or guardian(s) consent to let the doctors, nurses and employees of Hometown Pediatric Care (HTPC), do all things that may be need to diagnose, treat and care for the needs of above-referenced patient.
HTPC may keep, preserve and use or properly dispose of any tissue, samples, parts that are taken during procedure(s). These specimens may be used for diagnostic, teaching or research programs.
I understand this is a teaching facility and that I am included in its teaching, research and training programs.
I authorize HTPC to take photos, video or audio recording of me for diagnostic, teaching, identification, care conferencing, research and quality improvement purposes.
I understand that HTPC is not responsible for any personal belongings that are lost.
I am aware that the practice of medicine is not an exact science and acknowledges that no guarantees have been made to me about the result of my examination or treatment at HTPC.

Patient Rights and Responsibilities (see the other side of the page):
I understand I have the right to take part in decisions about my health care and plan for treatment. I have the responsibility to give complete information about my health history, follow the treatment plan and advise your healthcare team if you have changes in your health. I have had the opportunity to read the Patients Rights and Responsibilities and my questions have been answered.

Consent To Release Medical Information:
I consent to let HTPC share/release/exchange information such as physical, mental, drug, alcohol, HIV or AIDS (including information that state and federal law and accreditation agencies require) with my doctors, referring/referral health care provider; and/or to any insurance company or organization that helps pay my bill. HTPC may also give information to any welfare organization, to which I have applied or may apply for aid.
I consent to let HTPC share/release/exchange information regarding immunizations to my child's school and/or daycare as needed**. In response to COVID-19, I consent to let HTPC share/release "alternative diagnosis" with my child's school, daycare and/or employer as needed.**

Assignment of Insurance Benefits:
I assign to HTPC, my physician, and other healthcare professionals involved in my care, all my rights and claims reimbursement under any private health insurance policy, Medicaid or any other programs that I identify for which benefits may be available to pay the HTPC for medical services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

Financial Responsibility:
I (or guarantor, if appropriate) will pay all bills for my care including bills that insurance benefits do not pay. I certify that the information I have given HTPC regarding my insurance is accurate to the best of my knowledge. I understand that my co-pay, if applicable, is due at the time of the visit. If I do not pay my co-pay, a bill for the co-pay will be mailed and will include a $5.00 service charge. I understand that any balance that remains unpaid after 60 days, will incur a $5.00 service charge, to be assessed once every month. Any account with a balance that has no payments for 90+ days will be sent to collections and I will be responsible for additional fees associated with the collections process.

Hometown Pediatric Care's Price Disclosure:
I have a right to see a list of prices for common medical procedures. I can ask the Office Manager about this price list or my bill.

Removal from HTPC:
If I decide to stop my medical care against the advice of doctors, I understand that HTPC and doctor(s) are not responsible for any bad result after I leave.

Acknowledgment of Receipt of Notice of Privacy Practices:
I hereby acknowledge that I was provided an opportunity to read a copy of the Notice of Privacy Practice which sets for the ways in which my protected health information may be used or disclosed by HTPC and outlines my rights with respect to such information.

Annual General Consent:
I agree that this consent will be effective for one calendar year. If I wish to sign a new consent upon each visit, I can request a new form at that time. If I wish to change or revoke this consent, or if there is a change in custody, I will notify HTPC at my next visit.

BY SIGNING, I CONFIRM THAT I HAVE LEGAL ABILITY TO CONSENT FOR THE TREATMENT.

Signed_____ Signed _____
PARENT/GUARDIAN DATE PATIENT, IF 18 YEARS OR OLDER DATE

Signed:_____ _____
WITNESS DATE PRINTED NAME OF PARENT/GUARDIAN

PATIENT'S BILL OF RIGHTS

As a patient, parent or guardian at Hometown Pediatric Care, LLC, you can expect to:

1. Be partners with the medical staff in your care or the care of your child.
2. Be called by your preferred name.
3. Receive care from medical staff who respects your personal values, beliefs and customs regardless of your race, ethnicity, gender, religion, sexual orientation, gender identity or expression, cultural background, income level or socioeconomic status, physical or mental disability, education or illness.
4. Have medical staff listen to what you say, value your opinions and choices and answer your questions. Know that you can take part in developing your plan of care and that you can express your feelings and receive caring responses.
5. Receive prompt, thoughtful care.
6. Receive care and treatment in a safe and clean setting and be protected from harassment and abuse of any kind.
7. Be given as much information as you need to help you decide whether to consent to treatment or refuse it.
8. Have privacy during exams and treatment and have information about your illness kept private.
9. Have access to your medical record unless restricted by law. No one else will be given your medical information without your permission unless allowed by law.
10. Be taught what you need to know and do when you go home.
11. Make a suggestion or complaint to the Practice Manager (740-286-5455) and have your complaints heard and addressed.
12. Examine your medical bills and have the charges explained to you.

As a patient, parent or guardian at Hometown Pediatric Care, LLC, it is your responsibility to:

1. Give complete information about your health and health history.
2. Inform HTPC if there are changes to your address, phone number, insurance, ect.
3. Follow your treatment plan and tell your healthcare team if there are any changes in your condition.
4. Tell your healthcare team when you do not understand your care or what is expected of you.
5. Know if you refuse care, you are responsible for the outcome.
6. Follow the HTPC's rules out of respect for other families and medical staff. This includes notifying HTPC if you are unable to keep and appointment, respect for the property of others, controlling noise and following the no tobacco policy.