PEDIATRIC NEPHROLOGY of Alabama

GENERAL CONSENT FOR CARE

_____ **(Initial)** I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Pediatric Nephrology of Alabama, PC on an outpatient/office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Pediatric Nephrology of Alabama PC.

TELEHEALTH/TELEMEDICINE

_____ **(Initial)** I understand that telemedicine (defined as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care) may be offered to facilitate my medical care. Technologies include videoconferencing, the internet, store- and-forward imaging, streaming media, and landline and wireless communications may be used. I understand there are limitations with telemedicine visits, such as being able to conduct physical exams, which may limit my provider's ability to diagnose certain conditions. I understand that I may choose to opt out of telemedicine in favor of another appropriate and available method at any time. I understand that, as with any technology, telemedicine has technology limitations which may affect my provider's ability to fully complete a telemedicine visit. In the event of technology limitations, I understand my provider may need to end the telemedicine visit and discuss other treatment delivery options. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

ASSIGNMENT OF BENEFIT AGREEMENT

_____ **(Initial)** I hereby authorize my insurance company, including Medicare if I am a Medicare beneficiary, to make payments to Pediatric Nephrology of Alabama for medical or surgical services or items rendered to me or my dependent by Pediatric Nephrology of Alabama. Should my insurance carrier deny Pediatric Nephrology of Alabama payment, I understand that I am financially responsible for the charges. I authorize Pediatric Nephrology of Alabama to release all my medical records to my insurer, or any other third-party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update all personal, insurance and health information.

COMMUNICATION AUTHORIZATION

_____ **(Initial)** I authorize the use of the phone numbers and other contact information I provide, including my cellular number and any future number assigned to me, for calls, texts, emails, to include automated dialers, to contact me regarding

my care and my account by this medical provider and this medical provider's business associates.

PATIENT NAME(PRINTED): _____

LEGAL GUARDIAN/PARENT NAME (PRINTED) _____

LEGAL GUARDIAN/PARENT SIGNATURE
_____DATE_____

March 23, 2021