COASTAL PEDIATRIC ASSOCIATES

Consents, Authorizations, Notifications, and Agreements

*Patient Name*_____ *Date of Birth*_____

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Coastal Pediatric Associates (CPA). I/we consent to testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician, nurse practitioner, or physician assistant. I/we also consent to minor, procedural treatment, such as, but not limited to circumcision, ingrown toenail removal, frenulectomy, and cryotherapy if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations. I/we have read or have had read to me/us this consent and understand and agree to its contents. Initials _____

CPA offers patients the opportunity to connect to a provider through video visits (Skype/Facetime). By signing this, you are agreeing that you have had a chance to read through the eCONNECT informed consent and financial disclosure and agree to the terms set forth by the policy as well as had the opportunity to ask questions. I agree & understand that if I use eCONNECT I may be financially responsible for the service/visit and understand the risks and benefits of telemedicine. Initials _____

Consent for Clinical Trials

Since 2012, Coastal Pediatric Associates has been investigating medications, vaccines, and devices to better nourish and champion the health of all children and their families. Our experienced research team works alongside our capable clinic staff to provide you and your child the opportunity to participate in various clinical research studies! Studies may investigate anything from infant formula to adolescent medications, and we are always exploring new research areas. All study-related visits, procedures, and products are provided at no cost, and compensation for time and travel may be available.

Would you be interested in learning more about our clinical research program and how you can get involved? ☐ Yes ☐ No

Authorization for Release of Information and Assignment of Insurance Benefits

CPA is authorized to release any medical information required in the processing of applications or submission of information for financial coverage and the continuation of care, such as, but not limited to third party referrals to receive therapy services and treatment from specialists, including information referring to psychiatric care, drug and alcohol abuse, sexual assault, or tests for infectious disease including AIDS/HIV. I/we also agree to the release of medical, vaccination, medication history or other information about me/the minor to the state vaccination registry (CARES), pharmacy benefit managers via Surescripts, and/or government regulatory agencies (federal or state) as required by law. For Medicaid/Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicaid/Medicare benefits. Initials _____

Acknowledgement of Receipt of CPA Policies

I hereby acknowledge that I have received the CPA Notice of Privacy Practices, Financial Policy, Immunization Policy and Well-Exam Visit Helpful Facts. Initials _____

I/we understand that I have the right to refuse to sign this authorization and that my/our child's treatment will not be conditioned on signing. I/we understand that I/we have the right to revoke this authorization at any time by providing a written notification to the practice. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I/we understand that information used or disclosed as a result of this authorization may be subject to re- disclosure by the recipient and may no longer be protected by federal or state law.

I the parent/patient agree that my electronic signature will be valid for one year from date of issuance. The terms of this Agreement shall apply to each such renewal.

☑ I understand that checking this box constitutes my electronic signature as legal, and confirms that I acknowledge and agree to the above terms of Acceptance.

By signing below, I acknowledge that I have read and understand the above statements of Coastal Pediatric Associates:

Signature	Print Name	Date

WAYS TO SUBMIT ANNUAL PAPERWORK: You can **fax** completed form(s) to **843-584-8040**, **email** it to carecoordination@cpakids.com, or you may also **bring completed form(S) by one of our 4 locations.**