General Consent

☐ **Consent to Treatment and Services**

I authorize the physicians and other health care professionals who care for me or my child(ren) at Periscope Pediatrics LLC to perform or order diagnostic procedures and to provide medical treatment as seen fit and necessary in their professional judgement. This includes behavioral health, laboratory tests, radiology and diagnostic examinations, emergency and surgical treatment, medication and other services rendered to my child(ren) by Periscope Pediatrics under the orders of the treating providers or as required by Periscope Pediatrics LLC policies. I understand that I will be offered opportunities to ask questions and may decline consent for my child(ren) at any time before a treatment is rendered or a diagnostic test is begun. I also understand that I may be asked to put my decision to withdraw my consent in writing.

☐ **Teaching Activities**

I understand that Periscope Pediatrics LLC participates in various teaching programs for resident physicians and other providers to improve knowledge and compassionate care. I understand that **based on my and my child's consent**, as a result of Periscope Pediatrics participation in these teaching programs, I or my child(ren) may receive treatment by a medical or other resident in addition to my primary consulting physician and that students or other healthcare profession students may observe or participate in my care and I consent to all such treatment, observation or participation. I also understand that students, doctors in training or other trainees will be clearly identified as such and that it is my right to refuse to participate in such teaching practices.

☐ **Privacy Practices**

I acknowledge I have received, read and understand the Periscope Pediatrics LLC Notice of Privacy Practices, which contains a description of the uses and disclosures of my health information. I understand that Periscope Pediatrics LLC has the right to change its Notice of Privacy Practices from time to time, and that I may contact Periscope Pediatrics LLC at any time to obtain a current copy of the Notice of Privacy Practices.

☐ **Financial Responsibility**

I understand Periscope Pediatrics LLC is a concierge medical practice and as such does not accept insurance. Based on this, I am responsible for the monthly fees (as discussed during my annual renewal) and any in-person visits or treatment costs. Upon my request, Periscope Pediatrics LLC will provide a superbill when appropriate for me to submit to my insurance company for possible reimbursement.

ACKNOWLEDGEMENT AND AGREEMENT

I certify that I have received a copy, have read, understand and agree to the above, and that I am the patient or the patient's legal representative with the authority to sign documents on the patient's behalf.

Name (print)	Patient Signature	Date

Parent/ Legal Guardian	Patient Representative/Relationship (if under 18 years old)

Witness	Parent/Guardian #1
	Parent/Guardian #2