221 Pecan Park Avenue
Alexandria, LA 71303
Phone: 318-487-1602 | Fax: 1-877-526-9271

Date:

Patient Name:
DOB:

MINOR PATIENT CONSENT TO TREATMENT (17 YEARS OR YOUNGER)

I, **the parent/guardian of Bre Test**, authorize the rendering of such medical care, including diagnostic and therapeutic treatment by the provider(s) (physician or nurse practitioner) and staff of Mitchells Pediatrics, as may be deemed necessary or beneficial.
Treatment may include, but is not limited to laboratory procedures, capillary puncture, and medication administration.
I acknowledge that no guarantees have been made to the effect of the examination or treatment of my child's condition.
I understand that I have the right to make decisions concerning my child's healthcare, including the right to refuse medical treatment.
My signature below indicates my acknowledgement that I have read and agree to all the above.
I give my authorization and consent for treatment, and I understand that I may withdraw my consent for treatment at any time.

Parent/Guardian Signature: _____ **Date:**

ADULT PATIENT CONSENT TO TREATMENT (18 YEARS OR OLDER)

I, **Bre Test**, authorize the rendering of such medical care, including diagnostic and therapeutic treatment by the provider(s) (physician or nurse practitioner) and staff of Mitchells Pediatrics, as may be deemed necessary or beneficial.
Treatment may include, but is not limited to laboratory procedures, capillary puncture, and medication administration.
I acknowledge that no guarantees have been made to the effect of the examination or treatment of my condition.
I understand that I have the right to make decisions concerning my healthcare, including the right to refuse medical treatment.
My signature below indicates my acknowledgement that I have read and agree to all the above.
I give my authorization and consent for treatment, and I understand that I may withdraw my consent for treatment at any time.

Patient Signature: _____ **Date:**

MITCHELLS PEDIATRICS
CARING FOR KIDS EVERYDAY
221 Pecan Park Avenue
Alexandria, LA 71303
Phone: 318-487-1602 | Fax: 1-877-526-9271

Date:

Patient Name:
DOB:

OFFICE AND FINANCIAL POLICIES

1. **Accompaniment Policy:** At every visit and while on company premises, your child must be accompanied by a parent/guardian or an authorized adult whose name is listed in your child's medical records.
2. **Age Limitation:** Medical care will be provided to your child from newborn to age 18 and within 30 to 90 days of their 19th birthday to provide urgent medical care.
3. **Demographic Changes:** You must notify our staff immediately when either your Address, Telephone Number, Pharmacy or Email address has changed.
4. **Telephone Calls:** Leave a detailed message with our receptionist for our nurse or provider to call you back before end of day or within 24 hours after calls have been triaged.
5. **School or Medical Paperwork:** If you have paperwork to be filled out by the provider, you must allow at least 48 hours to pick up.
6. **Medical & Vaccine Record:** An updated vaccine record along with the appropriate VIS forms will be given to you when your child receives vaccines. If you allow someone else to pick up your child's vaccine or medical record, they must show form of unexpired ID and be listed as an authorized adult in your child's chart. Vaccine records will not be faxed or mailed unless a signed authorization to do so is received.
7. **Cell Phones:** No cell phone usage allowed in triage or exam rooms including photos and video recording.
8. **School & Work Excuses:** Excuses are given at the time of each visit; they will NOT be backdated unless cleared by provider.
9. **Food & beverages:** For the safety and cleanliness of our patients and staff, food and beverages may be limited in exam rooms during medical procedures or when there is a risk of exposure to blood or bodily fluids. Please follow staff instructions regarding food and drinks during your visit.
10. **ADHD/ADD:** Your child will have to be evaluated every 2-3 months to receive a refill. If you allow someone else to pick up your child's script, they must show ID and be listed as an authorized adult in your child's chart.
11. **Divorced Parents:** The parent who brings the child to the visit is responsible for the copayment before the time of service. We will not be involved in any legal matters.
12. **Insurance information:** It is your responsibility to provide CORRECT insurance(s) information. Failure to do so will result in you being responsible for any balances for unpaid claims.
13. **Copayments/Deductibles/Outstanding Balances:** Payments are due at the front desk before the time of service. We accept all major credit cards and cash. We no longer accept checks.
14. **Self-Pay:** Our current rate is $90/visit. We no longer offer payment plans, so the visit must be paid in full before the time of medical provider service.
15. **Overdue Balances:** Failure to remain in good financial standing with Mitchells Pediatrics could result in dismissal from the practice. Any overdue balances must be paid before your visit regardless of how old the balance is.
16. **Terms of Dismissal:** Our facility has the right to terminate the provider/patient relationship for non-compliance. Threatening or abusive behavior, tampering, altering or improper use of prescriptions or medications, falsification of clinical records such as school and work excuses, general dishonesty, and non-paying patients.
17. **After Hours:** A medical provider is on call 24/7. Please call (318) 487-1602 and leave a message AND we will return your call within 30-45 minutes. Please do NOT text or call the provider's personal phone for any medical issues related to your child (unless authorized by provider). Non-urgent medication requests will be completed during the next workday.

Parent/Guardian OR Patient Signature: _____ **Date:**

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PATIENT LAB POLICY AGREEMENT

When a provider at Mitchells Pediatrics orders medically necessary lab work at Rapides Outpatient Center, you will be given a specific timeframe in which the labs must be completed. This timeframe will be listed on your child's lab order and documented in their medical chart before you leave your appointment.

Please contact Rapides Outpatient Center (or whatever lab you prefer to use) to schedule your child's lab appointment within the required timeframe. If you are unable to get an appointment within that timeframe due to scheduling conflicts, please get the name of the person you spoke with and notify our office immediately at 318-487-1602.

Not completing lab work on time, or missing the follow-up appointment needed to review results, may delay or negatively affect your child's medical care.

Mitchells Pediatrics and its providers cannot be held responsible for negative outcomes that may occur if labs are not completed on time. Your cooperation is essential to ensure the best possible care for your child.
I acknowledge that I understand and agree to follow this policy.

Parent/Guardian OR Patient Signature: _____ **Date:**

Staff Signature: _____ **Date:**

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Alexandria, LA 71303
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Date:

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DOB:

NOTICE OF PRIVACY PRACTICES

I, the parent/guardian of Bre Test, have received a copy of the Notice of Privacy practices.

[We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information and how you can get access to this information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this notice, please ask to speak with our designated Privacy Officer.]

Parent/Guardian OR Patient Signature: _____ **Date:**

PATIENT RIGHTS & RESPONSIBILITIES

Rights

- To be informed of your rights and responsibilities before receiving care or discontinuing care.
- To have your individuality, psychosocial, spiritual, personal dignity, values, beliefs, privacy, and preferences respected.
- Equal care and treatment based on the American Academy of Pediatrics standards and guidelines; regardless of race, age, religion, national origin, sex, sexual preferences, physical impairment, diagnosis, ability to pay, or source of payment.
- To make informed decisions regarding care and participate in the development and implementation of care plans, treatment, and services.
- To receive information about your own health status in a timely manner.
- To sign an informed consent documenting a mutual understanding between the patient and physician about the care, treatment, and services the patient receives.

Responsibilities

- Tell the physician and nurse about present complaints, past illnesses, hospitalizations, and your medications - including over-the-counter medicines such as aspirin, ibuprofen, and dietary supplements like vitamins, diet pills, and herbals.
- Report to the physician and nurse for any perceived risks and unexpected changes in your condition.
- Follow instructions and guidelines given by those providing health care services.
- Advise the physician for any dissatisfaction regarding your care at Mitchells Pediatrics.

Parent/Guardian OR Patient Signature: _____ **Date:**