PEDIATRIC CONSENT TO CARE (RESPONSIBLE PARTY)

I, _____, the parent and/or legal guardian of, _____ consent to my child being provided with the healthcare offered by Kentucky Family Medicine, LLC, its employees, contract providers and any other partner associated with Kentucky Family Medicine, LLC, and herein after known as KFM. I will permit KFM to treat my child in ways they judge are beneficial to him/her. I understand that this care may include tests, including tests for reportable communicable disease, examinations, and medical and surgical treatments.

I acknowledge that no guarantees or assurances have been made or will be made with respect to the results of any such examinations, tests, or treatments, or the benefits, risks, or side effects thereof. The Commonwealth of Kentucky (KRS 214.625) established procedures affecting human immunodeficiency virus (HIV) or hepatitis B or hepatitis C viruses. In the event that a caregiver(s) is/are exposed to a patient's blood or bodily fluids, KFM is authorized to test the patient for human immunodeficiency virus (HIV) or hepatitis B or hepatitis C viruses. KFM is also authorized to release the test results to the exposed caregiver(s).

I acknowledge that if a caregiver is exposed to my child's blood or bodily fluids in the course of treatment, his/her blood will be tested for human immunodeficiency virus (HIV), hepatitis B, and hepatitis C viruses, and the results released to the exposed caregiver. If my child is exposed to the blood or bodily fluids of a caregiver in the course of treatment, the caregiver's blood will be tested for human immunodeficiency virus (HIV), hepatitis B and hepatitis C viruses, and the results will be released to me.

Authorization for Release of Medical Information

I UNDERSTAND THAT MY CHILD'S MEDICAL INFORMATION IS CONFIDENTIAL AND IS PROTECTED BY A PROVIDER/PATIENT PRIVILEGE, AND I AM WAIVING THE PROVIDER/PATIENT PRIVILEGE FOR KENTUCKY FAMILY MEDICINE, LLC.

I consent and authorize KFM to release all information contained in my child's financial and medical records, including information about communicable disease and serious communicable diseases and infections as defined by the Commonwealth of Kentucky statute and the department of Public Health rules, which include venereal disease (VD), tuberculosis (TB), human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS-related complex (ARC) to:

a. any of my child's treating providers and potential future providers;

b. any third-party payor or insurance company (including but not limited to, Medicare, Medicaid, maternal and infant health, commercial insurers, automobile no-fault insurers, worker's disability compensation insurers, and health maintenance organizations) which may be responsible, for whole or in part for paying for my child's health care services;

c. any other person or entity that is responsible for administration, billing, and collecting;

d. any other hospital, treating practitioner, or care facility that will provide (or potentially provide) subsequent medical/health care to ensure continuity of my child's care; and

e. any pharmacy or pharmacist;

f. any durable medical equipment vendor or product supplier that requires my child's medical records to justify services.

Financial Responsibility

I understand that regardless of my child's assigned insurance benefits, I am responsible for payment of the total charges for services rendered if they fall outside the scope of the health insurance agreement. I agree that all the amounts for which I am responsible are due upon request, or payment arrangements made between KFM and myself, and are payable to KFM. I certify that any information reported to KFM relating to health insurance, or lack thereof, is true correct, and complete to best of my knowledge.

This authorization will apply to the anticipated period of treatment and shall remain valid until KFM receives written notification that these authorizations, waivers, and comments have been rescinded. A photocopy of this authorization, or electronic copy, may be accepted in lieu of the original.

_____ _____ _____/_____/_____

Printed name of patient Signature of Parent or Guardian Date