Acknowledgement of Receipt & Understanding of Policies

Patient Name: Date of Birth:

Acknowledgement of Receipt of Financial Policy

_____ (initials) I understand and agree to the terms outlined in the MVP Kids Care Financial Policy

Acknowledgement of Receipt of No Show & Cancellation Policy

_____ (initials) I understand and agree to the terms outlined in the MVP Kids Care No Show & Cancellation Policy.

Acknowledgement of Receipt of Pro-vaccination Policy and Code of Conduct Policy

_____ (initials) I understand and agree to the terms outlined in the MVP Kids Care Pro-vaccination Policy and Code of Conduct Policy.

Acknowledgement of Receipt of Notice of Privacy Practices-Confidentiality, Privacy, Participation in Health Information Exchange, and HIPAA (Health Insurance Portability and Accountability Act).

_____ (initials) I have reviewed and understand a copy of the MVP Kids Care Notice of Privacy Practices.

_____ (initials) I agree to receive detailed messages relating to my Child's health information from MVP Kids Care at:

Email address: _____ Phone number: _____ (Home/Cell).

_____ (initials) I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

_____ (initials) I agree to receive electronic correspondence via the patient portal or through a 3rd part email service on behalf of MVP Kids Care.

Acknowledgement of Receipt of Consent to Treatment

_____ (initials) I have reviewed and understand a copy of the MVP Kids Care Consent to Treatment.

Authorized Individuals to Consent to Treatment and Record Information Release

I give my permission for the person(s) listed below to bring my child(ren) in for treatment, with the understanding that they will see or hear information about your child's medical treatment, and may possibly include protected medical, financial, or personal information included in your child's medical record. This person(s) may be asked to consent to diagnostic procedures, immunizations, and medical treatments. This person(s) must have your/child's insurance information (card), and must pay your co-pay, deductible, etc. And they must provide identification each time when accompanying your child(ren) to appointments. I understand that it is my responsibility to provide any and all legal documentation pertaining to guardianship or advance directives. I understand and accept the terms outlined above.

Authorized Individuals (including yourself): _____

Name/Relationship to Child	Phone Number
Name/Relationship to Child	Phone Number
Name/Relationship to Child	Phone Number

I acknowledge that I am responsible for ensuring all my questions and concerns have been answered regarding any of the above policies.

Signature of Parent/Guardian **Printed Name** **Date**

This consent for is valid for one (1) year from the date of the signature listed below.