GATEWAY PEDIATRICS, LLC

CONSENT TO TREAT | RELEASE OF INFORMATION | SINGLE CONSENT TO SHARE MEDICAL INFORMATION WITH CINs

1. CONSENT TO MEDICAL CARE: By my signature or electronic signature below, I warrant that I am the parent or legal guardian of the registered child(ren) named on Page 1 and/or 2 of the Patient Registration Form. I hereby request and authorize the physician and other healthcare providers of GATEWAY PEDIATRICS, LLC ("the Practice") and their professional staff, to perform any medical diagnostic procedures and medical or surgical care which in their professional judgment is deemed necessary to diagnose and/or treat the condition(s) that have brought about my seeking medical care services for my child(ren) at the offices of the Practice. I understand that the practice of medicine is not an exact science, and that there are risks and benefits associated with receiving medical treatment. I acknowledge and agree that no guarantees are made to me concerning the results and outcomes of the medical examination and treatment rendered by the physicians and professional staff of the Practice.

2. RELEASE OF MEDICAL RECORD INFORMATION: I hereby authorize the Practice to disclose all or any part or the contents of the medical record of the patients named on this Registration Form to such insurance companies, organizations, or agencies that may be concerned with the payment of medical services rendered to the registered patient(s) consistent with Federal HIPAA regulations. This authorization is given with full knowledge and understanding that such disclosure may contain information which may result in a valid denial of insurance benefits, or which otherwise may not serve the interests of the registered patient(s) or myself.

3. PRIVACY POLICY ACKNOWLEDGMENT: The Practice provides this *Consent Form* to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA). By signing this form, you are granting consent to the Practice, to use and disclose your/your child(ren)'s protected health information for the purposes of treatment, payment, and healthcare operations. Our *Notice of Privacy Practices* provides more detailed information about how we may use and disclose this protected health information (PHI). You have a legal right to review our *Notice of Privacy Practices* before you sign this consent, and we encourage you to read it in full. I acknowledge that I have received a copy of the *Notice of Privacy Practice* for GATEWAY PEDIATRICS, LLC.

4. HIV / HEPATITIS B OR C TESTING: I acknowledge that I am hereby informed in accordance with Title 18, Subtitle 3, Section 18-338.1 of the 2010 Code of Maryland, as amended, that if the provision of healthcare services to the registered patient(s) exposes any healthcare provider to the patient's body fluids in a manner which may transmit immunodeficiency virus or HIV or Hepatitis B or C viruses, then the patient shall be deemed to have consented to testing for infection with HIV or Hepatitis B or C viruses, and to the release of such test results to the person(s) exposed, as provided by law.

5. CORRECT INFORMATION: The undersigned certifies that he/she has provided correct information in this Patient Registration Form and understands that any false statements or concealment of material fact may be prosecuted under applicable federal and state laws. The undersigned further certifies that he/she has read, fully understands, and accepts the above information, terms and conditions, and is the patient's parent or legal guardian, duly authorized to execute the above and to accept its terms.

6. OFFICE VISITS: are by appointment only. Walk-ins are not given priority over parents who call for appointments per our policy.

7. LATE POLICY: Patients are asked to arrive 15 minutes before their scheduled appointment time in order to complete the check-in process. Patients arriving more than 10 minutes late may be required to reschedule their appointment to the next available opening consistent with the type of appointment requested. Only acutely ill children will be worked into the provider's schedule later the same day.

8. CHILDREN UNDER 18 MUST HAVE A PARENT / GUARDIAN PRESENT: Children under the age of 18 cannot legally consent to their own treatment. Treatment can only be approved by a parent or legal guardian. If you cannot attend their appointment and must send your child(ren) alone, or with an older sibling, grandparent, or nanny, please be aware that they have no legal authority to provide a "consent to treatment" for your child. You must send a SIGNED LETTER OF AUTHORIZATION WITH THEM, or give us written pre-authorization naming the person(s) you approve in advance to consent to treatment on your behalf.

9. CLINICALLY INTEGRATED NETWORKS (CIN): As a part of our commitment to improve the quality and the coordination of medical care for the children we serve, GATEWAY PEDIATRICS, LLC has elected to participate in the Children's National Pediatric Health Network (PHN) and Johns Hopkins Clinical Alliance (JHCA) Clinically Integrated Networks (CINs). This innovative program provides real-time coordination of care via an electronic medical record that allows an interface between your child's primary care pediatrician and some of the country's leading hospitals. This SINGLE CONSENT will allow us to share information, for example, with an ER doctor treating you/your child, or with a specialist to whom you have agreed we are to refer you/your child, so that they are able to quickly access critical information about you/your child from his/her medical record before beginning treatment. This should dramatically reduce the chance of medical errors including adverse drug interactions and allergic reactions. You/Your child's health care information is encrypted (encoded) **and can be accessed only by health care providers who are caring for you/your child and have a need to know**. As GATEWAY PEDIATRICS, LLC is a part of Clinically Integrated Networks, this written SINGLE CONSENT will allow the sharing of information with any provider within the CINs whom you have elected to be involved in the treatment of your child. You do have the option to opt out of SINGLE CONSENT. If you choose to opt out, you will need to sign a separate consent form for each and every time your child needs to be seen by another member of the Children's National PHN or Johns Hopkins's JHCA other than those at GATEWAY PEDIATRICS, LLC.

10. TELEHEALTH: Our *Consent to Treat - Telehealth* provides more detailed information about Telemedicine at Gateway Pediatrics, LLC. You have a legal right to review our *Consent to Treat - Telehealth* before you sign this consent, and we encourage you to read it in full. Access at https://www.gatewaypediatrics.com/wp-content/uploads/2022/12/TelehealthConsenttoTreat_2023.pdf I acknowledge that I have received a copy of the *Consent to Treat - Telehealth* for GATEWAY PEDIATRICS, LLC, either via paper or electronic means.

11. PATIENT'S RIGHTS: I understand that patient information will be stored electronically for my provider's records, and that an electronic health summary will be available to other providers through CINs. I also understand that I have the right to not share (opt out) health information with other providers within the CIN(s).

PROTECTED DISCLOSURE OF INFORMATION: I understand that GATEWAY PEDIATRICS, LLC, Children's National CIN, and Johns Hopkins CIN (collectively CINs) complies with all federal and local regulations including Health Insurance Portability and Accountability Act; and that this SINGLE CONSENT includes my agreement that GATEWAY PEDIATRICS, LLC and CINs can use private health information for treatment of my child as defined in the Notice of Privacy Practices. I agree to GATEWAY PEDIATRICS, LLC and CINs use of de-identified health information about my child for appropriately reviewed and approved research and quality improvement activities.

Signature/Electronic Signature of Parent/Guardian:_____ Date:_____