WHOLE PEDIATRICS GROUP

GENERAL CONSENT FOR TREATMENT

This form confirms your consent for me to provide medical care to your child.

Patient Information

Child's Name: _____ **Date of Birth:** _____

Parent/Guardian Name: _____

Today's Date: _____

Your Authority to Consent

By signing this form, you confirm that you are:

- ☐ The child's biological or adoptive parent
- ☐ The child's legal guardian (court-appointed)
- ☐ A person with legal authority to make medical decisions for this child

If you are a legal guardian or have custody through court order, please provide documentation.

Consent to Examination and Treatment

I consent to Dr. Connell Bost and Whole Pediatrics Group providing medical care to my child, including:

- ✓ **Physical examinations** - Routine and sick visit exams
- ✓ **Preventive care** - Well-child visits, immunizations, screenings
- ✓ **Diagnosis and treatment** - For illnesses, injuries, and medical conditions
- ✓ **Procedures** - Minor procedures appropriate for office-based care
- ✓ **Medications** - Prescribing medications when appropriate
- ✓ **Tests** - Lab tests, diagnostic studies as needed
- ✓ **Referrals** - To specialists or other healthcare providers when needed
- ✓ **Counseling and education** - Developmental guidance, parenting support, health education

Understanding of Risks

I understand that:

- ✓ **All medical care involves risks** - Even routine care can have unexpected outcomes
- ✓ **No guarantees** - Dr. Bost cannot guarantee specific results or outcomes
- ✓ **Diagnosis can be uncertain** - Sometimes symptoms don't lead to clear diagnoses
- ✓ **Treatment can have side effects** - Medications and procedures can cause adverse reactions
- ✓ **Complications can occur** - Even with excellent care, complications are possible

I acknowledge that Dr. Bost has not made any guarantees about the results of treatment.

Right to Ask Questions

I understand that I have the right to:

- ✓ Ask questions about my child's condition, diagnosis, and treatment
- ✓ Receive clear explanations in language I can understand
- ✓ Request additional information or clarification
- ✓ Discuss treatment options and alternatives
- ✓ Understand risks and benefits before consenting to specific procedures

I am encouraged to ask questions and will do so before any treatment I don't understand.

Right to Refuse Treatment

I understand that I have the right to:

- ✓ Refuse any recommended treatment or procedure
- ✓ Seek a second opinion
- ✓ Request a different approach
- ✓ Change my mind after initially consenting (before treatment begins)

If I refuse recommended treatment, Dr. Bost will explain the potential consequences of refusal.

I understand that refusing medically necessary treatment could harm my child's health.

Emergency Care Authorization

In the event of a medical emergency:

☐ **If I am present:** I will make decisions about emergency care

☐ **If I cannot be reached:** I authorize Dr. Bost to:

- Provide emergency medical care
- Call 911 and arrange emergency transport
- Make urgent medical decisions in my child's best interest
- Contact emergency contacts listed in my child's chart

I understand Dr. Bost will make every reasonable effort to contact me before providing emergency care, but in life-threatening situations, care will be provided immediately.

Emergency Contact Information:

Primary Contact: _____ **Phone:** _____

Secondary Contact: _____ **Phone:** _____

Immunizations

☐ I consent to immunizations recommended by the CDC/AAP schedule
☐ I wish to discuss immunizations before they are given
☐ I am declining some or all immunizations (requires separate Vaccine Refusal form)

I understand that immunizations are important for my child's health and the health of the community, and that declining vaccines may put my child at risk for serious illness.

Disclosure of Information

I authorize Dr. Bost to:

- ✓ Discuss my child's care with me via phone, email, text, or in person
- ✓ Share information with other healthcare providers involved in my child's care
- ✓ Coordinate care with specialists, hospitals, or other facilities when needed
- ✓ Report required information to schools (immunization records when required by law)
- ✓ Report to public health authorities as required by law (communicable diseases, etc.)

Additional persons authorized to receive information about my child's health:

(These people may call and receive information, pick up prescriptions, etc.)

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

I understand I can modify this list at any time by submitting a written request.

Adolescent Confidentiality

I understand that California law gives adolescents the right to consent to certain healthcare services without parental involvement, including:

- Contraceptive services
- Pregnancy testing and prenatal care
- STI testing and treatment
- Certain mental health services
- Substance abuse treatment

In these limited situations, Dr. Bost may not be able to share certain information with me without my child's permission.

Dr. Bost encourages open communication between parents and adolescents and will work to facilitate this while respecting confidentiality rights.

Custody and Consent Issues

☐ Both parents have equal rights to consent to medical care
☐ There are custody restrictions (provide court order)
☐ Only one parent has legal authority (provide documentation)

If there are custody restrictions, parental rights limitations, or court orders affecting medical decision-making, I must provide documentation to Whole Pediatrics Group.

Understanding the Direct Primary Care Model

I understand that:

- ✓ This is a membership-based direct primary care (DPC) practice

- ✓ Dr. Bost does not bill insurance for membership services
- ✓ I am responsible for membership fees as outlined in the Financial Terms
- ✓ This practice is not a substitute for emergency care or specialty care
- ✓ I should maintain health insurance for hospital, emergency, and specialty care

Financial Responsibility

I understand that I am financially responsible for:

- ✓ Monthly membership fees
- ✓ Additional service fees (house calls, ear piercing, circumcision)
- ✓ Any services not included in membership
- ✓ Payment is required regardless of insurance coverage

Medical Records

I understand that:

- ✓ Dr. Bost will maintain medical records for my child
- ✓ I have the right to access and request copies of these records
- ✓ Records are confidential and protected under HIPAA
- ✓ Records may be shared with other providers when appropriate for my child's care

See the Notice of Privacy Practices for complete details about how health information is used and protected.

Communication Preferences

My preferred method of communication is:

☐ Phone call to: _____
☐ Text message to: _____
☐ Email to: _____
☐ Patient portal message

I understand I can change my communication preferences at any time.

Consent and Acknowledgment

By signing below, I confirm that:

- ✓ I have the legal authority to consent to medical care for this child
- ✓ I consent to examination and treatment as described above
- ✓ I understand that all medical care involves risks
- ✓ I understand my right to ask questions and refuse treatment
- ✓ I authorize emergency care if I cannot be reached
- ✓ I have read and understand this consent form
- ✓ I have had the opportunity to ask questions
- ✓ I am signing this consent voluntarily

This consent remains in effect for the duration of my child's care at Whole Pediatrics Group unless I revoke it in writing.

Parent/Guardian Name (print):

Signature:

Date:

Relationship to child:

☐ Mother ☐ Father ☐ Legal Guardian

Second Parent/Guardian (if applicable)

Name (print):

Signature:

Date:

Relationship to child:

☐ Mother ☐ Father ☐ Legal Guardian

For Office Use Only

☐ Legal guardianship documentation on file
☐ Custody order on file
☐ Both parents have equal rights
☐ Emergency contacts verified

Staff Initials: _____ **Date:** _____