BLUEBIRD KIDS HEALTH CONSENT AND AUTHORIZATION FORM

CONSENT TO TREAT

I, the parent or legal guardian of the named patient ("Patient"), or the legal adult Patient (if 18 or older), consent to health care services provided to Patient by Palm Beach Pediatrics, LLC, part of Bluebird Kids Health (collectively, "Bluebird Kids Health"), and its care teams. This consent allows Bluebird Kids Health to provide, solicit or arrange for medical care, testing, treatment for the Patient including, but not limited to:

- Evaluations, screenings and physical examinations;
- Prescribing and administering medications, immunizations and injections;
- Diagnostic and laboratory testing;
- Emergency care and minor in-office procedures;
- Coordination of healthcare services, including referrals to specialists;
- Services provided by telehealth, including video, phone, or other digital communication.

For the avoidance of doubt, I understand and agree that this consent and authorization serves as written parental consent under the Florida Parent's Bill of Rights (§ 1014.06 Fla. Stat.) as applicable.

The care teams that provide or arrange these health care services may include physicians, nurse practitioners, physician assistants, clinical supervisors, other licensed professionals, and appropriate individuals under the supervision of a licensed provider (including students and trainees). Members of these care teams are not always directly employed by Bluebird Kids Health.

I acknowledge that I have the right to accept or refuse any medically-necessary treatment of the Patient, unless otherwise required by law, and that I may discuss all treatments with the Patient's care team.

I understand that medical treatment may involve risks to the Patient, including the risk of injury or death, and that medical diagnosis or treatment does not guarantee any particular outcome or result. I understand that telehealth has potential risks different from in-person care, including technical issues or equipment failures that could result in transmission errors, lost information, or delays in care.

I understand that this Consent and Authorization Form must be signed in order for Patient to receive medical care at Bluebird Kids Health, and that this consent to treat Patient will remain in effect until revoked in writing.

☐ I agree to the terms and conditions of the Consent to Treat.

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I consent to the use or disclosure of the Patient's protected health information by Bluebird Kids Health for the purpose of diagnosing and providing treatment, obtaining payment for health care bills, to conduct the health care operations of Bluebird Kids Health, or as otherwise permitted by law. These uses and disclosures are further described in Bluebird Kids Health Notice of Privacy Practices.

I authorize Bluebird Kids Health to request, use, and disclose the Patient's medication prescription history from and to other healthcare providers and/or third-party pharmacies as needed for medical treatment.

I understand the use of telehealth services may involve electronic communication of Patient's personal medical information to third-parties used to facilitate the provision of telehealth services.

I consent to the release of the Patient's health and financial information to Patient's health insurance providers and similar entities, including commercial and governmental payers, as necessary for billing and reimbursement.

I understand by signing the Universal Patient Authorization Form attached to this form that Bluebird Kids Health will be able to access, use and disclose all of my health information from all information sources in accordance with applicable law, including to and from the Floridia Health Information Exchange.

I understand that I can request a restriction on how my health information is used or shared by Bluebird Kids Health, but that Bluebird Kids Health may not be able to fulfill my request.

☐ I agree to the terms and conditions of the Authorization for Use and Disclosure of Health Information and acknowledge that I have received a copy of the Bluebird Kids Health Notice of Privacy Practices, which describes how Patient's health information may be used and disclosed by Bluebird Kids Health, as well as Patient's rights regarding such information. I understand Bluebird Kids Health may update this Notice from time to time, and I understand that that the most recent version of this Notice is available on the Bluebird Kids Health website or from a Bluebird Kids Health office upon request.

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

I agree to notify Bluebird Kids Health of all health insurance benefits available to Patient, and any changes to those benefits. I assign and authorize Bluebird Kids Health to receive direct payment of insurance benefits for services provided to Patient. I understand that I am financially responsible for any charges not covered by the Patient's insurance, including co-pays, deductibles, and payment for non-covered services. I agree to pay all fees not covered by insurance at the time of service. I understand that, unless otherwise required by law, I am financially responsible for all charges that could have been covered by any insurance benefits available to Patient that I did not timely disclose to Bluebird Kids Health or otherwise prevented Bluebird Kids Health from billing.

I understand that the individual who brings the Patient to an appointment may be held financially responsible for any charges incurred at that visit. I understand that unless otherwise required by law, Bluebird Kids Health may charge fees for missed appointments, checks returned due to insufficient funds, and collections activities. I acknowledge that the full Bluebird Kids Health Financial Responsibility Policy is available on the Bluebird Kids Health website.

☐ I agree to the terms and conditions of the Assignment of Benefits and Financial Agreement.

OTHER PARENTS OR LEGAL GUARDIANS

Please list Patient's other parent(s) or legal guardian(s) below. I understand these individuals will have the right to consent to health care services provided by Bluebird Kids Health to Patient, to receive and authorize the release of Patient's protected health information, and will be financially responsible for Patient's care as described in the Bluebird Kids Health Financial Responsibility Policy. For policies specific to divorced or separated parents, please see the Bluebird Kids Health Divorced or Separated Parents Policy.

1. **Full Name:** _____
   - **Relationship to Patient:** ☐ Parent ☐ Legal Guardian
   - **Phone Number:** (____) _____
2. **Full Name:** _____
   - **Relationship to Patient:** ☐ Parent ☐ Legal Guardian
   - **Phone Number:** (____) _____

OTHER AUTHORIZED ADULTS

I authorize the following other responsible adults to bring Patient to medical appointments at Bluebird Kids Health, receive protected health information and health updates about Patient and consent to health care services provided by Bluebird Kids Health to Patient if I am not available to do so. I understand in order to consent to treatment, these other authorized adults must be Patient's stepparent, grandparent, adult sibling, adult uncle or aunt, or Patient's legal healthcare surrogate or healthcare power of attorney under Florida law. I understand this authorization does not depend on Bluebird Kids Health being able to successfully reach me or Patient's other parent or legal guardian on the date of the appointment, and that this authorization will remain in effect until revoked in writing.

1. **Full Name:** _____
   - **Relationship to Patient:**

     ☐ Stepparent ☐ Grandparent ☐ Adult Sibling ☐ Adult Uncle / Aunt

     ☐ Legal Healthcare Surrogate or Healthcare Power of Attorney under Florida Law

   - **Phone Number:** (____) _____
2. **Full Name:** _____
   - **Relationship to Patient:**

     ☐ Stepparent ☐ Grandparent ☐ Adult Sibling ☐ Adult Uncle / Aunt

     ☐ Legal Healthcare Surrogate or Healthcare Power of Attorney under Florida Law

   - **Phone Number:** (____) _____

CONSENT TO ELECTRONIC COMMUNICATIONS AND MARKETING COMMUNICATIONS

I authorize Bluebird Kids Health to communicate information related to Patient's treatment, payment for services, and the healthcare operations of Bluebird Kids Health by electronic means, including email, text messages, phone calls, voicemails or other similar channels. These communications may include, but are not limited to appointment reminders, patient experience surveys, billing notices, and health updates.

☐ I agree to the terms and conditions of the Consent to Electronic Communications.

I further authorize Bluebird Kids Health to use my name, contact information, and other similar items of Patient's protected health information for marketing purposes (for example, notifications about community events, educational and wellness classes, and referral programs) consistent with federal and state privacy laws. I understand Bluebird Kids Health will not receive direct or indirect payment from any third-parties for these communications. I understand that this authorization is voluntary, and I can revoke it at any time by contacting Bluebird Kids Health at consent@bluebirdkids.com. Revoking this authorization will not impact my ability to receive care from Bluebird Kids Health.

☐ I agree to the terms and conditions of the Consent to Marketing Communications.

ACKNOWLEDGEMENT OF PRACTICE POLICIES

I acknowledge that I have received and reviewed all practice policies of Bluebird Kids Health and that any questions regarding these policies have been answered to my satisfaction. I agree to comply with all applicable policies, including but are not limited to the:

- Vaccine Policy
- Divorced or Separated Parents Policy
- Financial Responsibility Policy
- Patient Discharge Policy
- Patient Centered Medical Home Overview

I acknowledge that Bluebird Kids Health may update these policies from time to time, and I understand that the most recent version of the policies are available on the Bluebird Kids Health website. I understand that failure to comply with practice policies may result in Patient's discharge from the practice.

☐ I agree to the terms and conditions of the Acknowledgement of Practice Policies.

SIGNATURE AND ATTESTATION

By signing below, I confirm and attest that I have read, understand, and agree to the information, terms, and conditions outlined in the Bluebird Kids Health Consent and Authorization Form, and freely provide the consents and authorizations described therein. I certify that the information I have provided, including about my and Patient's identity, contract information, insurance benefits, and financial data is true, accurate and complete to the best of my knowledge.

PATIENT INFORMATION

Patient's First Name: _____ **Middle:** _____ **Last:** _____
Date of Birth: _____

Name of Parent or Legal Guardian (if applicable) _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature of Parent/Legal Guardian of Patient or Patient (if 18 or older):

_____

Date: _____