General Consent and Authorizations

1. General Consent For Treatment

This is to certify that I, the undersigned, whether signed as guarantor or as patient, voluntarily consent to the administration and performance of diagnostic procedures and medical treatment by authorized agents and the employees of Fayetteville Children's Clinic and by its medical staff or their designees as may, in their professional judgment, be deemed necessary or beneficial. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment.

2. Authorization To Release Medical Information

I hereby authorize Fayetteville Children's Clinic to release the medical records and/or other information including copies concerning treatment to the following for the purpose of obtaining approval and processing claims for payment of medical expenses incurred:

- Governmental agencies or programs or health maintenance organizations (HMO);
- Preferred provider organizations and/or insurance companies;
- The utilization review organization contracted by my employer, insurance company or governmental agency or program;
- Physicians or healthcare institutions responsible for further care or follow-up treatment to serve the goal of continuation of my care.

This authorization includes the release of medical records and/or information concerning drug abuse, drug-related conditions, psychological, psychiatric conditions and/or communicable diseases (including AIDS), if applicable. I understand that I may revoke this authorization at any time except to the extent that action has already been taken. REDISCLOSURE IS PROHIBITED WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS.

3. Assignment Of Insurance Benefits

I hereby authorize payment directly to Fayetteville Children's Clinic of any benefits herein specified and otherwise payable to me but not to exceed the office's regular charges for any office visits. I understand that I am financially responsible to Fayetteville Children's Clinic for charges not covered under this assignment.

4. Financial Agreement

I, the undersigned, agree whether signed as guarantor or as patient, that in consideration of the services to be rendered to the patient, I do hereby guarantee payment to Fayetteville Children's Clinic on demand for all charges for said services incurred on behalf of such patient. In the event that the undersigned fails to pay on demand or in payment installments established by the practice and the account is turned over to a collection agency and/or attorney for collection, I hereby agree to pay all collection cost and expenses.

5. Personal Valuables

THE PRACTICE IS NOT RESPONSIBLE FOR VALUABLES OR PERSONAL BELONGINGS AND WILL NOT REIMBURSE ME IF ANY ARTICLES ARE LOST, STOLEN OR DAMAGED DURING MY OFFICE VISIT.

6. Consent To Documentation Tool

I consent to the use of the Artificial Intelligence (AI) scribe dictation technology in the documentation of my medical records at Fayetteville Children's Clinic. I understand this tool is intended to improve accuracy, communication, and continuity of care among my healthcare providers. You have the right to withdraw your consent at any time.

7. Consent To Share Electronic Health Information

I authorize Fayetteville Children's Clinic to share my health information electronically with my other health care providers to better coordinate my care. This includes medical history, diagnosis, medications, diagnostic testing and results, family history, substance use/abuse records, mental health records, and other sensitive health information. I am aware I can revoke this consent at any time by notifying the office.

8. Prescription History

I authorize Fayetteville Children's Clinic to request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

DATED THIS _____ **DAY OF** _____, _____

I THE UNDERSIGNED, CERTIFY THAT I HAVE READ AND UNDERSTAND THE FOREGOING. I FURTHER CERTIFY THAT I AM LIABLE TO FAYETTEVILLE CHILDREN'S CLINIC UNDER FINANCIAL PROVISIONS HEREIN ABOVE STATED.

Parent or Guarantor	**To be Witnessed by an Employee of Fayetteville Children's Clinic**