Valencia Pediatric Associates
Office Procedures and Policies

Permission to Obtain Labs/X-Ray
I give any doctor at Valencia Pediatric Associates permission to obtain lab, x-ray, or immunization information from any source for my child.

Consent For Treatment Of An Unaccompanied Minor In An Emergency
We the undersigned, parent(s) or guardian(s) do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment that may be rendered to said minor under the general special instructions of **Valencia Pediatric Associates**, whether such diagnosis or treatment is rendered at the office of said medical group or at a licensed hospital.
It is understood that consent is given in advance of any specific diagnosis or treatment being required by any person into whose custody minor is entrusted and said physician to exercise his best judgment as to the requirements of such diagnosis or treatment. This consent shall remain effective until revoked.

Acknowledgment of Notice of Privacy Practices
I understand that as part of my health care, Valencia Pediatric Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality

I understand that Valencia Pediatric Associates maintains a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that Valencia Pediatric Associates reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional written copy of this notice at any time. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed.

Our Notice of Privacy Practices is posted in our office and on our website. If you would like a copy please ask the receptionist.
I have had an opportunity to receive and review the *Notice of Privacy Practices* of Valencia Pediatric Associates.

Acknowledgement of “Abuse Free Zone”
At Valencia Pediatric Associates we appreciate and respect our staff. It is our belief that our staff should have a work environment free from verbal and physical abuse. We expect each one of you to treat each one of our staff members as you would like to be treated. Outbursts against our staff will not be tolerated and may result in your discharge from the practice.