INTERMED
Care without compromise.

Pediatric Patient Authorization Form

Patient's Legal Name:_____ **Date of Birth:** _____
First MI Last (preferred) MM/DD/YYYY

Consent for Treatment: I (print name of parent or legal guardian) _____ consent to routine medical treatment and/or evaluation including but not limited to laboratory and x-ray examinations. I understand that separate consents will be requested for certain special procedures. I also understand I have the right to refuse any proposed procedure or treatment.

Signature: _____ **Date:** _____

Preferred Primary Contact

Parent/Legal Guardian Name: _____
First Last

Mailing Address:_____
Street City State Zip

Email Address:_____ **Relationship to patient:** _____

Preferred Telephone Number: ☐ Home ☐ Cell ☐ Work	**Okay to leave a detailed voice message?** *May contain medical and/or prescription*
Home: (_____)_____- _____	☐ Yes ☐ No
Cell: (_____)_____- _____	☐ Yes ☐ No
Text message communication: InterMed utilizes text messaging to better serve patients in a convenient manner including appointment reminders, important visit instructions and non-specific clinical information. Message and data rates may apply. I understand I may revoke my election to receive texts by reaching out to InterMed at any time. Please see other side of document for additional information.	☐ I consent to receive text messages ☐ I do **not** consent to receive text messages
Work: (_____)_____- _____	☐ Yes ☐ No

Secondary Contact *(Please list anyone who has decision making authority on behalf of the patient)*

Parent/Legal Guardian Name: _____
First Last

Mailing Address:_____
Street City State Zip

Email Address:_____ **Relationship to patient:** _____

Preferred Telephone Number: ☐ Home ☐ Cell ☐ Work	**Okay to leave a detailed voice message?** *May contain medical and/or prescription*
Home: (_____)_____- _____	☐ Yes ☐ No
Cell: (_____)_____- _____	☐ Yes ☐ No
Work: (_____)_____- _____	☐ Yes ☐ No

Primary Coverage	Insurance Carrier:	Subscriber ID:	Group #:
Secondary Coverage	Insurance Carrier:	Subscriber ID:	Group #:

Emergency Contact Information: Please specify your preference for communication should an emergency arise, and the parent/legal guardians are unavailable.

Emergency Contact Name:_____ Relationship:_____
First Last

Emergency Telephone: (_____)_____ (_____)_____ (_____) _____
Home *Work* *Cell*

Continue to other side →

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Communication Authorization: You may specify up to three individuals authorized to receive routine verbal communication about your healthcare other than mental health treatment. Disclosure of mental health treatment status requires execution of InterMed's release of information. Please provide their first and last names, and the information you authorize to be shared with each individual.

Name:	☐ Prescription Request ☐ Referral Request	☐ Request a new Appointment ☐ Request Changes to Appointment	☐ Medical inquiries/status updates
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MyInterMed Patient Portal Enrollment: MyInterMed is a secure, web-based platform that allows you and your care team bi-directional communication about your non-urgent matters. You can also view your medical record, upcoming appointments, lab results, request prescription refills, & more. Usage of the portal is restricted to communication regarding your care and is not to be used to communicate about the care of others. Enrollment is free.

☐ Enroll me

☐ Do **not** enroll me

☐ Currently Enrolled

Carequality/Commonwell Health: To facilitate primary care and communication with other healthcare practitioners or facilities who have been or may become involved in my care both within and outside the State of Maine I agree to be enrolled in Carequality and Commonwell Health. These are tools that InterMed uses to exchange data with other providers in real-time including pertinent clinical information to assist in the delivery of care, especially in emergency situations; to clinical and non-clinical personnel who may now or in the future become involved in both the management and transition of my care between hospitals, medical practices, other health care facilities and home including care coordination and case management services; and for other lawful functions

☐ Enroll me

☐ Do **not** enroll me

☐ Currently Enrolled

Satisfaction Surveys: InterMed seeks patient feedback after each visit to continuously improve the patient experience. These surveys may be conducted via automated dialing service and/or an artificial or prerecorded voice.

☐ I consent to receive surveys

☐ I do **not** consent to receive surveys

This authorization should be updated every 12 months. This authorization will remain current until an updated version is received, or this version is revoked in writing. I understand I have the right to revoke this authorization in writing at any time. Revocation will not cover information that has already been released. **I understand that I will need to complete InterMed's Authorization to Release Health Care Information form or provide an equivalent HIPAA compliant authorization if I wish to allow my provider to discuss health information not covered by the categories listed above.**

_____ _____

Patient/ Legal Guardian Signature **Date**