

**Patient Portal Application and
Informed Consent and User Agreement**

Patient(s) Information

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

E-mail Address _____

Responsible Party/Parent

Name _____ Date of Birth _____

Relationship to Patient _____

Address _____
Street City State ZIP

Security Question and Answer: _____

Purpose of this Form

All Children Pediatrics, PLLC ("Practice") offers a secure way for its patients to view certain parts of their health information maintained in an electronic health record and to communicate with their physician and office staff. While secure messaging can facilitate communications, it has certain risks. In order to manage these risks, there are some conditions of participation. This form is intended to document that you have been informed of these risks and conditions of participation, that you accept the risks, and that you agree to the conditions of participation and to the Practice's Patient Portal Policies and Procedures and as they may be amended or superseded from time to time.

How the Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information or attachments. Secure messages and information can only be read by someone who knows the correct password or token to log in to the portal site.

Protecting Your Private Health Information and Risks

This method of communication prevents unauthorized parties from being able to access or read message while they are in transmission. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address and only the correct individual (or someone authorized by that individual) must be able to access it. Only you can make sure these two factors are present. Please make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account, so that only you, or someone you authorize can see the messages you receive from us.

Conditions of Participating in the Patient Portal

Access to this secure web portal is an optional service and we may suspend or terminate it at any time and for any reason. If we do suspend or terminate this service, we will notify you as promptly as we reasonably can.

By signing below, you acknowledge that you have read and agree to comply with the Practice's Patient Portal Policies and Procedures, which have been provided to you. If you do not understand or do not agree to comply with or do not consent to our policies and procedures, please do not sign this form. If you have any questions or need further information, please let us know before signing the form.

Patient Consent and Agreement:

Patient or Parent/Guardian Signature _____

Date _____