



PATIENT CONSENT, AUTHORIZATION & AGREEMENTS

PATIENT NAME: _____ DATE OF BIRTH: _____

PARENT/LEGAL GUARDIAN NAME: _____

- 1) **Consent to medical treatment:** I consent to procedures that may include, but are not limited to, examination, laboratory tests, injections and immunizations, and medical treatment.

Parent/Guardian Initials _____

- 2) **Release of Information:** I authorize Petite Pediatrics to release any information contained in my medical record to treating physicians, insurance companies, professionals and/or agencies in my health care.

Parent/Guardian Initials _____

- 3) **Financial Agreement:** I understand it is my personal obligation to pay for services rendered in accordance with the regular rates and terms of Petite Pediatrics. All initial visits are due and payable at the time of service. All subsequent office visits, which are not paid for at the time of service, are due and payable in full within 30 days from the date of service.

Parent/Guardian Initials _____

- 4) **Assignment of Insurance Benefits:** For patients covered by Cottage Health System insurance: I authorize my insurance carrier to pay for benefits covered by this assignment and to send their payment directly to Petite Pediatrics. I also understand that any office visit copayment is due at the time of service.

Parent/Guardian Initials _____

I certify that I have read the foregoing and accept the terms stated above.

Parent / Legal Guardian Signature

Date