PARTNERS IN PEDIATRICS, PLC
4684 Wenmar Drive Saginaw, MI 48604

CONSENT FORM FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Child Name: ________________________________ DOB: _______________________________

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physician and staff have the necessary medical and protected health information (PHI) to provide the highest quality medical care possible, while protecting the confidentiality of the PHI of our patients to the highest degree possible.

I hereby give my consent to Partners In Pediatrics, PLC for the purpose of treatment, payment and healthcare operations for the above named child.

I hereby give my consent for the above named child to be treated by Partners In Pediatrics, PLC, in my absence, for emergency care.

I hereby give my consent for medical information pertaining to a diagnosis, be given to other facilities required for further testing and treatment of that diagnosis, with our referral.

I hereby give my consent for the information of name, birth date, address, telephone number, insurance, and parent's information, including social security numbers, and employer to be given out for obtaining payment of services rendered and/or referrals for further treatment.

Our office policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the front office or business manager. If the account is not paid within 90 days of the date of service and no financial arrangement has been made, I will be responsible for any expenses incurred in collecting the account.

I hereby authorize payment of benefits directly to the provider for services rendered to my child. I further authorize Partners In Pediatrics, PLC to release any information required to process insurance claims.

Any information pertaining to HIV/AIDS, Mental Health, or Substance Abuse Treatment will require a specific written authorization for release.

OPTIONAL:
I give my consent for my child's medical information to be shared with the caregivers listed below:
(List any relatives, daycare providers, nurses, or other's that may care for your child other than parents or guardians.)
I give Partners In Pediatrics, PLC consent to discuss and disclose any and all health information with the person or persons listed below in our office, or by phone. The parties listed below have my permission to sign and give consent for vaccine administration. The parties listed below may also pick up prescription orders for controlled substances.

Please list complete names:

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By signing this notice I am agreeing to the above statements, and have the right to revoke this consent and authorization at any time.

___________________________________ ___________________________ ______________________

Signature Relationship Date

Effective Date: April 14, 2003
Revised 8/10/10
Revised 9/19/2013