Consent to Treat

Patients Name(s): ______________________________ **DOB:** __________

______________________________ __________

______________________________ __________

______________________________ __________

Parent/Legal Guardian: ______________________________ **Date:** __________

Relationship: ______________________________

Consent for Medical Treatment: I give consent to Chopra Pediatrics, its staff, physicians and other practitioners to provide and perform medical care, tests, screenings, and other services that are deemed necessary or beneficial by the practice and the American Academy of Pediatrics for my child(s)/ren(s) health and well-being. I also give consent for Chopra Pediatrics to have access to my pharmacy records for improved medical management.

Financial Agreement: I agree that in consideration for the services rendered to my child/ren, to pay all amounts for which I am financially responsible, in accordance with the rates and terms of the Practice. I understand that to the extent permitted by law, where insurance or other third-party benefits are insufficient to pay for the services rendered, that I will be responsible for payment of any balances due. I understand that if I have not provided Chopra Pediatrics with accurate and current information regarding my insurer at the time of services rendered, I will be responsible for the costs of all care for that date of service. I agree to pay all bills when presented with a statement.

Release of Information: I understand that Chopra Pediatrics will release my health information to any requesting health care provider for future diagnosis, treatment or care; to any person on entity which is responsible for billing/collection of claims for medical services; to any insurance companies, HMO or third party payors.

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