

Comprehensive Pediatrics, Inc.  
Patient Consent Form

I, \_\_\_\_\_ (Parent/Guardian) hereby authorize the attending physician and/or such physicians and assistants as may be selected by him/her, to diagnose and treat the condition or conditions from which my child is suffering by such means including diagnostic exam/testing and in-office procedures, as he/she believes indicated by his/her studies of my case.

I further consent to the preservation and/or disposal of all body fluids, test tissue or other parts removed and/or obtained during the office visit.

I am aware that the practice of medicine and surgery is not an exact science, that complications may occur, and that no guarantees have been made to me concerning the results of my medical treatment.

**Consent to Release Information**

I, \_\_\_\_\_ (Parent/Guardian) hereby authorize Comprehensive Pediatrics, Inc. and the physician(s) responsible for my child \_\_\_\_\_ care, at their discretion, to disclose any and/or all information, including copies of my child's medical record concerning any hospital admission and/or treatment, to physicians providing follow-up care; and all review organizations employed by employer and/or insurance carrier and/or third party payer which may be liable for all or part of the medical care charges or who may be responsible for determining the necessity, appropriateness, amount or other matters related to the medical care charges for care provided; and to Comprehensive Pediatrics, Inc. for Peer Review or Quality Assurance activities. This authorization includes the release of medical records and/or information concerning drug abuse, or drug-related conditions, alcoholism, psychological and psychiatric conditions, and communicable diseases. I hereby authorize this physicians' office to disclose and release any and all pertinent billing information to any organization responsible for services such as radiology, pathology; or any other physicians providing service. I hereby authorize the physician to disclose and release and/or all information, including copies of my child's medical record to my employer and those working on behalf of my employer.

I consent to the use of social security numbers for the purposes of patient identification.

**Guarantee of Account**

In consideration of services rendered to the above-mentioned patient, I guarantee to Comprehensive Pediatrics, Inc. for all charges incurred on behalf of the above named patient, including any portion not paid by my insurance organization, Medicare or Medicaid. Many insurance carriers have very specific and explicit rules for receiving medical treatment in order for the services rendered to be paid by that carrier. These rules may include: identifying a Primary Care Physician; receiving prior authorization from their Primary Care Physician before having an office visit with a specialist; receiving prior authorization before obtaining laboratory or radiology services. Failure to comply may result in the patient or guarantor being responsible for payment.

**Assignment of Insurance Benefits**

In consideration of services to be rendered, I assign, transfer and convey all rights, titles and interest due me from my insurance organization, Medicare and Medicaid in payment on my behalf to Comprehensive Pediatrics, Inc.

**This authorization will remain in effect for one year from the date of this signature.**

I acknowledge that the treatment for which I give this consent has been fully explained to me and I have read and fully understand this authorization applies to me.

\_\_\_\_\_  
Parent/Guardian/Administrator/Next of Kin

\_\_\_\_\_  
Date

Copy of Practice Privacy statement signed with parent/guardian on: \_\_\_\_\_

Patient unable to sign privacy statement due to: \_\_\_\_\_