CHILDREN'S MEDICAL GROUP, P.A.

_____ _____

Patient Name Date of Birth

GENERAL CONSENT FOR MEDICAL CARE, TREATMENT AND TESTING:

I do hereby voluntarily consent to such care encompassing diagnostic and therapeutic procedures and medical treatment as may be ordered by my/my child's physician or designees, as is necessary in their judgment. I understand that I am free to ask questions at any time and that I may discuss my questions and receive answers in language I understand and to my understanding prior to receiving any such treatment.

INSURANCE:

I hereby assign to Children's Medical Group, P.A. all rights, benefits and interest under any insurance policy, health plan or other third party liable to me, in consideration for services rendered by Children's Medical Group, P.A. I hereby authorize payment directly to Children's Medical Group, P.A. of all third party liability insurance coverage, third party payor health plan and individual liability insurance coverage for medical expenses incurred as a result of any accident, injury, or illness for which I received treatment at Children's Medical Group, P.A.

RELEASE OF INFORMATION:

I authorize Children's Medical Group, P.A. as holders of medical or other information about me/my child to release to insurance companies, health plans, agencies or representatives of any companies handling my/my child's claims any information needed for this or any other claims.

PATIENT RESPONSIBILITY:

I understand that I am financially responsible to Children's Medical Group, P.A. for all physician fees, tests and other such treatment ordered by the physician and further agree to pay any collection or attorney fees which may occur as a result of non-payment for treatment rendered by Children's Medical Group, P.A. I understand that payment is due when services are rendered.

I also understand that Children's Medical Group, P.A. shall bill all insurance companies and third party payers if they are contractually obligated to do so. If my insurance fails to pay for any services provided to me/my child, I hereby acknowledge that I am responsible for any unpaid balances that are deemed my responsibility by any insurance companies or third party payers. Furthermore, I understand I am responsible for any co-payment, co-insurance amounts and/or deductibles.

I understand that if my insurance requires a referral, Children's Medical Group, P.A. will need at least twenty-four (24) hours to complete my referral.

I understand that if I want copies of my/my child's medical records there is a fee of $20 for the first 20 pages, $1 per page for pages 21-80 and $0.50 per page thereafter unless the records are sent directly to another health care provider.

** A person under 18 years of age is considered a minor. If you are under 18 years of age, this form must be signed by your parent or legal guardian.

I hereby certify that I have read and understand this form and I accept all its terms.

_____ **X**_____ **X**_____

Date Signature of Patient (if 18 years or older) Signature of Parent/ Legal Guardian

Parent/Legal Guardian Address:_____

Parent/Legal Guardian Phone #:_____