Authorized Consent to Seek Medical Care & Release

I am providing my current insurance information along with my copayment or full payment for the services rendered.

I also understand if After Hours Pediatrics is unable to obtain payment from my insurance company I am responsible for payment in full for services rendered to my child/children while under the care of the above named person.

**Copay must be paid by the authorized adult bringing the child in for services.

For patients 16 years and older ONLY. Patient listed below may present and be treated unaccompanied by an adult.

Yes _____ No _____ (parent please initial one)

☐ I do NOT authorize anyone other than the parents stated on the New Patient Paperwork to seek medical care for my child. (only mom or dad may bring patient to the office)

_____ ___/____/____
Parent/Legal Guardian Signature Date

If you are allowing someone other than the parents to bring in the child (grandparents, nanny, aunt/uncle, etc. or in case parents are at work or out of town), please complete and sign below.

I (parent/legal guardian), _____ am hereby giving permission for the following person to bring my child/children to After Hours Pediatrics and to receive medical treatment and advise during my absence.

Name _____ DOB _____ Relationship _____

Name _____ DOB _____ Relationship _____

Name _____ DOB _____ Relationship _____

Please specify dates: From _____ to _____ (ex. 18th birthday or a week you will be out of town and child will be in the care of someone else)

We will continue to rely on the information on this form unless you request changes. It is your responsibility to immediately notify After Hours Pediatrics of a divorce, legal separation, change in custody arrangement, or any other circumstance which may alter this authorization.

CONSENT & RELEASE

CONSENT TO TREATMENT: I understand that medical treatment of an urgent nature is necessary for the patient and that such medical care, treatment and procedures will be performed by physicians and non-physician employees of After Hours Pediatrics during normal operating hours . I understand that medical treatment only is being provided, and that no responsibility will be taken for long-term patient care or care after normal hours of operation. I hereby grant my authorization and consent for such treatment and procedures, and certify that no guarantee of assurance has been made as to the results which may be obtained.

AUTHORIZATION FOR PROMOTIONS: I authorize After Hours Pediatrics to use my written comments, my name, and my photographs for promotional purposes. **(Y / N) Initial:** _____

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY: I hereby assign all medical and/or surgical benefits to which I am entitled, including government sponsored programs, private insurance and other healthy plans to After Hours Pediatrics. This assignment shall remain in effect until revoked by me in writing. I hereby authorize said Assignee to release all information necessary to secure the payment which is to be issued directly to After Hours Pediatrics for their services as described herein. I understand that I am financially responsible for all charges whether or not paid by said insurance. I promise to pay After Hours Pediatrics all charges, copayments, deductibles and coinsurance amounts for services rendered to or on behalf of the patient at the time of service. I further agree to pay all collection costs and attorney fees should the account become delinquent and be referred to a collection agency.

I certify that all information is correct and the insurance is in effect as of today. I have read the above policy and agree to pay for all services not covered by my insurance. I understand that it is my responsibility to verify and know my insurance policy and my PCP. I authorize After Hours Pediatrics to request/release any medical information from or to another physician or medical institution as necessary for my medical care or filing purposes.

OUT OF NETWORK PLANS ONLY: I understand that After Hours Pediatrics will file my insurance claims for services rendered to the patient as an out-of network or non-contracted provider. I understand that I will be financially responsible for all applicable non-paid charges. **Initial:** _____

_____ _____/_____/_____
Patient Name **Patient's Date of Birth**

_____ _____/_____/_____
Parent/Legal Guardian Signature **Date**