Divino Niño Pediatrics, PLLC

General Consent Form

GENERAL CONSENT TO TREATMENT

I do hereby authorize Divino Nino Pediatrics and the assistant/s that she may designate to perform the treatment/procedure(s) that are reasonable, necessary and advisable. I have been informed of the reasons for the treatment/procedure(s), along with the expected benefits, risk and possible consequences involved.

Understanding this, I authorize Divino Nino Pediatrics to perform such examinations, treatment, laboratory tests and to administer such medication as, in his or her opinion, are necessary or advisable for my son/daughter whose name appears above. I understand I may withdraw my consent at any time, to see the extent permitted by law.

INSURANCE AUTHORIZATION

I hereby authorize direct payment of medical benefits to Divino Nino Pediatrics services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance, including co-insurance amounts, deductibles and copays.

I certify that the information given by me applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

CONSENT FOR USE AND DISCLOSURE

I have been offered a copy of and have had full opportunity to read and consider Divino Nino Pediatric Notice of Privacy Practices. This notice provides a description of our treatment, payment activities and healthcare operation of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information.

I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information as described on the Notice of Privacy to carry out treatment, payment activities and healthcare operations.

Patient name **Last Name** **DOB**

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Parent/Guardian Signature: _____ **Date:** _____