PEDIATRICS WEST, P.C.

CONSENT OF **PARENTS/GUARDIANS OF MINOR PATIENTS**
TO DISCLOSE HEALTH INFORMATION FOR PAYMENT,
TREATMENT AND HEALTH CARE OPERATIONS

PLEASE PRINT CLEARLY

Patient's Name: _____ Patient's Date of Birth: _____
First MI Last

Patient's Address: _____ _____
Street City State Zip Code

Parent Name: _____ Parent Name: _____
First & Last First & Last

Primary Phone Number: _____ **Secondary** Phone Number: _____

Parent's e-mail: _____

Patient's Primary Care Physician _____

ACKNOWLEDGEMENT OF RECEIPT OF PEDIATRICS WEST'S (the "PRACTICE") NOTICE OF PRIVACY PRACTICES:
By my signature below, I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

CONSENT TO DISCLOSE MY CHILD'S GENERAL HEALTH INFORMATION:
By my signature below, I hereby authorize the Practice to disclose my child's medical information so that the Practice may treat my child, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g. quality assurance). I also authorize the Practice to disclose my child's medical information to insurers and providers outside of the Practice when necessary so that these providers may treat my child; seek payment for that treatment, and for the purpose of their health care operations. I also authorize the Practice to disclose my child's medical information on my home answering machine or voicemail.

The following family members/friends have my permission to accompany my child to his/her medical appointment: (please list only people over the age of 18 and their relationship to the patient. For example: Tom Jones, grandfather)

☐ None

_____ _____ _____ _____
Name Relationship to patient Name Relationship to Patient

_____ _____ _____ _____
Name Relationship to Patient Name Relationship to Patient

ASSIGNMENT OF INSURANCE BENEFITS:
By my signature below, I authorize medical benefits to be paid to Pediatrics West, P.C. on my child's behalf for any service provided by the medical and clinical staff of the practice. I understand that I am responsible for all charges not covered by insurance for this service date as well as all future service dates.

ASSIGNMENT OF RECEIPT OF PRACTICE'S NOTICE OF THE BILLING POLICY:
By my signature below, I hereby acknowledge that I have received a copy of the Pediatrics West Patient Policies.

_____ _____ _____
Signature Relationship to Patient Today's Date (MM/DD/YYYY)

_____
Print Name