



**OHIO
PEDIATRICS
INC**

Consent to Treat Acknowledgement of Financial Responsibility

The undersigned patient or individual acting on behalf of the patient agrees to the following:

1. Authority is granted to Ohio Pediatrics, Inc. to render needed treatment and/or tests to the patient.
2. I authorize Ohio Pediatrics, Inc to release any information required for payment of insurance claims.
3. I authorize my insurance or Medicaid benefits to be paid directly to the physician, realizing I am responsible to pay non-covered and unauthorized charges.
4. I understand that I am responsible for all charges incurred through Ohio Pediatrics, Inc. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.
5. I have been given Ohio Pediatrics Guidelines on missed appointments and understand my responsibilities regarding being late or absent.
6. Parent or legal guardian consent must be provided for treatment of a child (under 18 years of age) at each visit. If you are unable to accompany your child to each visit, you must provide written consent for treatment and designate below specific person(s) authorized to accompany your child to the visit on your behalf. This person(s) must be an adult over the age of 18.

Name _____ Relation to Child _____

Name _____ Relation to Child _____

Preventive Visits and Immunizations

Preventive visits are an opportunity to provide education on your child(ren's) growth and development as well as directly address concerns you may have. Many times important details may not be available from care givers, older siblings or grandparents. Also during preventative care visits, important immunizations are administered. It is vitally important that you understand the risks and benefits of each immunization by reviewing the vaccine information sheet for each vaccine given. **As physicians, we would prefer that the parent or legal guardian be present for these visits.**

7. In the event of an emergency, I designate the following person as my emergency contact:

Name _____ Daytime phone # _____

Address _____ Alternative phone # _____

City/State/Zip _____

8. Expirations or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or other individual(s) of legal entity to do so by court order or law.

Signature of Parent or Legal Guardian

Date