FINANCIAL POLICY & CONSENT TO TREAT

Patient(s) Name: _____
Date of Birth: _____/_____/_____

Race: O American Indian/Alaskan Native O Asian O Black/African American
O Hawaiian Native/Pacific Islander O White O Declined to Specify
Ethnicity: O Unknown O Hispanic O Non-Hispanic O Declined to Specify
Language: _____ O Declined to Specify

O **CONSENT FOR ONLY PARENTS TO BRING IN PATIENT**

O **CONSENT TO PERMIT INDIVIDUALS OTHER THAN PARENTS TO ACCOMPANY CHILDREN FOR TREATMENT** (Authorize nanny/grandparent/step-parent/sitter to accompany child(ren) to Heights Pediatrics, P.C. for the provision of medical services and to view/discuss child's protected health information.) Please list all names of individuals allowed to bring in your child(ren).
Name(s): _____
The individuals listed above are allowed to consent to:
O Immunizations O Lab Orders O X-Rays O In-House Tests (strep, RSV, Flu, Urine, etc.)
Name (s): _____
O Immunizations O Lab Orders O X-Rays O In-House Tests (strep, RSV, Flu, Urine, etc.)

USE THE FORM BELOW IF YOUR CHILD IS OVER 13 YEARS OLD & ALLOWED TO COME TO OUR OFFICE ON THEIR OWN
O **CONSENT TO TREAT UNACCOMPANIED MINOR AT HEIGHTS PEDIATRICS, P.C.** (Request and authorize Heights Pediatrics, P.C. and its personnel to deliver medical care, including routine immunizations, in house testing (strep, RSV, Flu, Urine, etc.), lab work and/or treatments (nebulizer, etc.) to MINOR CHILD)
Child's Name: _____ Date of Birth: _____/_____/_____
Child's Name: _____ Date of Birth: _____/_____/_____

*If permitting another individual or your minor child to come to Heights Pediatrics, P.C. alone, please provide us with a credit card to keep on file to cover cost of each visit including: co-pays, co-insurances, deductibles
Name on Card: _____ Cardholder Signature: _____
Card Number: __ __ __ __-__ __ __ __-__ __ __ __-__ __ __ __ Expiration: __ __/__ __ Zip Code: _____

I/We may be reached at the following phone numbers during my child(ren)'s appointment:
Parent/Guardian Name: _____ Phone: (_____)_____-_____
Parent/Guardian Name: _____ Phone: (_____)_____-_____

* I have read and understand this office policy and agree to comply and accept the responsibility for any payment due. For healthcare operations, we may use and disclose protected health information for our health care operations, including but not limited to the Dept. of Health immunization registry, health insurance quality review, etc.. I have received a copy of the HIPAA, Financial Policy & Consent to treat form.

Parent/Guardian Name: _____
Parent.Guardian Signature: _____ Date: _____/_____/_____