FINANCIAL POLICY & CONSENT TO TREAT

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Patient's Full Name: ____ Date of Birth: _____/_____/_______

Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American
☐Hawaiian Native/Pacific Islander ☐White ☐Decline to Specify

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Decline to Specify

Language: _________________________ ☐Decline to Specify

Preferred Pharmacy: ___________________________ Phone: (________)______-_______ Zip Code: ___________

CONSENT TO TREAT:

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

☐ **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): ____

These individuals are able to authorize procedures such as (check categories):

☐ Immunizations ☐ Lab Orders ☐ X-Rays ☐ In-house Tests (strep test, RSV test, flu test, urine test, etc.)

☐ **CONSENT TO TREAT UNACCOMPANIED MINOR AT HEIGHTS PEDIATRICS, P.C. [13 YEARS AND OLDER]**

(Request and authorize Heights Pediatrics, P.C. and its personnel to deliver medical care to my MINOR CHILD. This includes routine immunizations, in house lab work and treatments.)

Child's Name: ____ Date of Birth: _____/_____/_______

Child's Name: ____ Date of Birth: _____/_____/_______

Heights Pediatrics, P.C. is authorized to maintain credit card payment information in our confidential files. Your signature authorizes us to review the information and keep the card on file to cover the cost of each visit including: co-pays, co-insurances, and deductibles.

Name on Card: ____________________________________ Cardholder Signature: ____________________________

Card Number: __ __ __ __- __ __ __ __- __ __ __ __- __ __ __ __ Exp Date: __ __/__ __ 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: (________)________-_________

By signing, I have read and understand this office policy and agree to comply and accept the responsibility for any payment due. We may use and disclose protected health information for our healthcare 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. I also consent to receiving text messages for recalls (charges may apply from your phone provider).

☐Decline texts

Parent Name & Signature: ____

Date: ______/________/________ Reviewed & Entered by Staff Member: __________