IMPORTANT INFORMATION/PLEASE READ CAREFULLY
MUST BE SIGNED BY PATIENT IF OVER 18 YRS OLD

PATIENT NAME:_____D.O.B._____

CONSENT FOR TREATMENT AND PAYMENT PROCEDURES

I give permission for *Farmington Pediatric & Adolescent Medicine, LLC*, to interview, examine, and perform necessary laboratory/radiological procedures and to provide appropriate treatment to me.
Signed:_____Relationship_____Date_____

I hereby authorize *Farmington Pediatric & Adolescent Medicine, LLC* to furnish any necessary information concerning me to my insurance carriers, to other medical personnel to whom *Farmington Pediatric & Adolescent Medicine, LLC* has referred me for treatment, and to the admitting hospital should I be admitted for treatment.
Signed:_____Relationship_____Date_____

I understand that all professional charges are charged to the patient. Payment for these services is due at the time of service. Patients covered under a contracted insurance plan are required to pay any co-payment, deductible, or co-insurance at the time of service.
NOTE: Divorce has no bearing on the responsibility for medical care as it affects third parties. **YOU ARE EXPECTED TO PAY THE CHARGES DUE FOR THE SERVICE RENDERED THAT DAY**. *Farmington Pediatric & Adolescent Medicine, LLC* does not participate in payment disputes between parents. I understand that **Insurance/Medicaid cards should be presented at EVERY VISIT**.
Signed:_____Relationship_____Date_____

CONSENT FOR IMMUNIZATIONS

I give permission for *Farmington Pediatric & Adolescent Medicine, LLC* to administer all standard immunizations as recommended by The American Academy of Pediatrics schedule for immunizations. I understand that I will be advised in writing the benefits and risks associated with each immunization at the time of administration.
Signed:_____Relationship_____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have received, or have been given the opportunity to receive, a copy of the HIPAA Notice of Privacy Practices for *Farmington Pediatric & Adolescent Medicine, LLC*. Copies are available at the front desk.
Signed:_____Relationship_____Date_____

CONSENT FOR E-PRESCRIBING MEDICATION HISTORY

I understand that my prescriptions may now be transmitted electronically to area pharmacies. In order to provide valuable clinical information to my provider, I give permission for my medication history of the past two years to be obtained from Pharmacy Benefit Managers.
Signed_____Relationship_____Date_____