Farmington Pediatric & Adolescent Medicine

PATIENT NAME: _____ DOB: _____
PATIENT NAME: _____ DOB: _____
PATIENT NAME: _____ DOB: _____
PATIENT NAME: _____ DOB: _____
PATIENT NAME: _____ DOB: _____
PATIENT NAME: _____ DOB: _____

CONSENT FOR PAYMENTS AND PRODECURES

I give permission for *Farmington Pediatric & Adolescent Medicine, LLC* to interview, examine, and perform necessary laboratory/radiological procedures and to provide appropriate treatment to the above named patient. Permission for evaluation and treatment is granted whether the patient is presented by parent, other family member, unrelated third party, or is unaccompanied. _____ initial

I hereby authorize *Farmington Pediatric & Adolescent Medicine, LLC* to furnish any necessary information regarding the above named patient to my insurance carriers, to other medical personnel to whom *Farmington Pediatric & Adolescent Medicine, LLC* has referred this patient for treatment, and to any admitting hospital for this patient. _____ initial

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. WHOEVER BRINGS THE CHILD IS EXPECTED TO PAY THE CHARGES DUE FOR THE SERVICES RENDERED THAT DAY. *Farmington Pediatric & Adolescent Medicine, LLC* does not participate in payment disputes between parents. _____ initial

I understand that **insurance cards, including Medicaid cards**, are to be presented at every visit. _____ initial

CONSENT FOR IMMUNIZATIONS

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

ACKNOWEDGEMENT 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. _____ initial

CONSENT FOR PRESCRIBING E-PRESCRIBING MEDICATION

I understand that prescriptions may now be transmitted electronically to a pharmacy. In order to provide valuable clinical information to the prescribing provider, I give permission for a medication history to be obtained from Pharmacy Benefit managers for the preceding two years for the above named patient. _____ initial

Name of guardian (or patient if older than18) _____Date_____

Signature of guardian (or patient) _____Relationship_____

NOTE: This document will remain in effect as long as the custody of the child remains the same. In the event of a custodial change, or upon reaching the age of 18, a new consent form will be necessary.