



**ADVANCED PEDIATRICS
LIFETIME CONSENT FORM**

CONSENT FOR TREATMENT

The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures and surgery as required by the physician rendering care for themselves and/or their child(ren). Procedures may include, but are not limited to, minor surgery, laboratory work, allergy therapy, and x-rays.

HIV/HEPATITIS B & C VIRUSES TESTING NOTIFICATION

In accordance with Virginia law, any patient to whose body fluids a healthcare worker has been exposed will be deemed to have consented to HIV/HEPATITIS B & C testing. In all other cases, the patient shall have the right to informed consent or refusal for HIV/HEPATITIS B & C testing. *We do not randomly test for HIV.*

AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS

I authorize Advanced Pediatrics to apply for benefits for services rendered to myself or my minor child(ren) and to assign payment of benefits directly to Advanced Pediatrics. I authorize Advanced Pediatrics to contact my employer or insurance company regarding coverage and benefits.

RELEASE OF MEDICAL INFORMATION

I authorize Advanced Pediatrics to release any medical records or information necessary for insurance processing, payment, or coordination of care, and authorize any hospital, lab, or healthcare provider to release records to Advanced Pediatrics for the same purposes.

REFERRALS AND AUTHORIZATIONS

I understand it is my responsibility to obtain any required referrals, pre-certifications, or authorizations for services such as specialty care or diagnostic testing. I must also notify Advanced Pediatrics of emergency room visits within 48 hours, or as required by my insurance. Failure to do so may result in reduced or denied coverage, for which I am responsible.

FINANCIAL AGREEMENT

I agree that payment in full is due at the time of service. I am responsible for all charges incurred. (Jointly and severally if more than one) I understand that I'm responsible for all charges and agree to pay them. I may also get separate bills from other providers, such as doctors, radiologists, or labs. Fees are subject to change. . Any questions or disputes concerning insurance coverage or payment of benefits is a matter between the insurance subscriber/policy holder and the insurance company. Missed appointment fees: \$75 for general visits, \$150 for consults (if not cancelled 24 hours in advance). Evening/weekend fee: \$30 (in addition to any copay). Additional fees may apply for certain services. Balances are due within 30 days of service. Accounts in collections are subject to dismissal from practice. Questions or billing inquiries: 703-938-5555 (Option 7) or billing@advancedpediatrics.com

COPY OF SIGNATURE

A copy of this authorization and signature may be used in place of the original for all insurance and medical record purposes.

CERTIFICATION

I certify that the insurance information provided is accurate and that I have read, understood, and agree to the terms outlined above. I understand that the parent/guardian requesting treatment is responsible for this bill regardless of any legal agreement with another party. This authorization remains valid until revoked in writing.

Signature: _____ Relationship: _____ Date: _____