Patient Name ______________________ Date of Birth ______________

# Authorization for Treatment

I hereby request and give my permission for the physicians' office of The Pediatric Specialists Medical Group to provide such medical examination and treatment as they deem best for the child's physical or mental welfare.

As parent ( ), or legal guardian ( ), I give full consent to Dr.'s Hasell, Pham, Hernandez, or Chris Pope ARNP, for medical examination and treatment for my child. I will notify the physicians' office of any change in the above information or permission.

The undersigned agrees to accept full responsibility for all charges due upon receipt of statement. I direct my insurer and third parties to pay directly to the physicians' office any insurance benefits due for services on behalf of the patient and I hereby assign to the physicians' office all my rights to receive payments from my insurer and third parties for services rendered in the physicians' office. I understand that I am responsible for any costs incurred in the collection of the patient's account in case of default, including reasonable attorney fees and/or court costs.

I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis and treatment may be released to the natural mother, natural father, stepmother/stepfather, referring physicians, other physicians involved in the care of my child, and my insurance company/companies.

Signature of parent/legal guardian ______________________ Date ______________

I, ______________________, parent or legal guardian of the above patient, gives permission to ______________________, to seek medical treatment of my child.
(Print name of person authorized)

______________________
Signature of notary

______________________
Notary stamp

Patient Name ______________________ Date of Birth ______________________

# Authorization to Treat a Minor

I hereby request and give my permission for the physicians of The Pediatric Specialists Medical Group to provide medical services including examination and treatment (except for immunizations) that they deem best for my child's (16 and above) physical or mental welfare.

As the parent ( ), or legal guardian ( ), I give full consent to Dr.'s Hasell, Pham, Hernandez, or Chris Pope ARNP, for office medical examination and treatment for my child (16 and above) in my absence. I will notify the physicians office of any change in the above information or permission.

**As parent/guardian, I understand that each appointment must be confirmed via phone with me 1-2 days prior to the appointment and that if the appointment is not confirmed then it will be necessary to reschedule to a later date. I further understand that the office staff must speak directly with me to confirm that my teen will be coming to his/her appointment without a parent/guardian and that I am aware of the reason for said appointment.**

The undersigned agrees to accept full responsibility for all charges due upon receipt of statement. I direct my insurer and third parties to pay directly to the physicians office any insurance benefits due for services on behalf of the patient and I hereby assign to the physicians office all my rights to receive payments from the insurer and third parties for services rendered in the physicians office. I understand that I am responsible for any costs incurred in the collection of the patient's account in case of default, including reasonable attorney fees and/or court costs.

I agree that unless I give specific instructions otherwise, medical information regarding my child's diagnosis and treatment may be released to the natural mother, natural father, stepmother/stepfather, referring physicians, other physicians involved in the care of my child, and my insurance company/companies.

______________________ ______________________

Signature (Parent/guardian) Date

I, ______________________, parent or legal guardian of the above patient, give permission for The Pediatric Specialists Medical Group to treat my teenage child in my absence.

______________________

Signature of Notary

______________________

Notary Stamp