PEDIATRIC SPECIALTY PARTNERS

Consent to Treat Form

1. *For a patient under 18 years of age or unable to give consent*:
   I, _____ (parent/guardian name) give permission for Pediatric Specialty Partners to give my child, _____ (child name), DOB, _____ medical treatment.

   For a patient 18 years or older:
   I, _____ (patient name), DOB _____, give permission for Pediatric Specialty Partners to give me medical treatment.

2. I understand that payment for treatment is due at the time of service.

3. I allow Pediatric Specialty Partners (PSP) to file for insurance benefits to pay for care I receive, other than PSP physician fees. This care may include but is not limited to facility fees for surgical procedures, anesthesiologist fees, and medications requiring insurance authorization.

   I understand that, if PSP files for insurance benefits:

- PSP will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

4. I understand that:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

_____ _____
Patient's Signature Date

_____ _____
Parent or Guardian Signature Date
(for children under 18)

_____
Print name