

Pediatric Treatment Consent and Parent Financial Agreement

Please complete this form to authorize medical treatment for your child and to acknowledge your financial responsibility. This document is formatted for printing and physical archiving.

1. Patient Information (Child)

Child's Full Name:

Date of Birth (MM/DD/YYYY):

Gender:

2. Parent or Legal Guardian Information

Parent/Guardian Full Name:

Relationship to Child:

Phone Number:

Email Address:

Billing Address:

City, State, Zip Code:

3. Consent for Pediatric Medical Treatment

I, the undersigned parent or legal guardian, hereby authorize the medical providers and staff to administer medical care, diagnostic procedures, and prescribed treatments to the child named above. I understand that this consent is ongoing and remains in effect until revoked in writing.

4. Parent Financial Agreement

By signing below, I acknowledge and agree to the following financial terms:

- I am financially responsible for all charges associated with the care and treatment provided to my child.
- I agree to pay all co-pays, deductibles, and non-covered services at the time of service.
- I authorize the clinic to release necessary medical information to my insurance provider to process claims.
- I understand that I am responsible for any remaining balance after insurance benefits have been applied.

5. Acknowledgment and Signatures

I certify that I have read, understood, and agree to the terms of this Pediatric Treatment Consent and Parent Financial Agreement.

Printed Name of Parent/Guardian:

Signature of Parent/Guardian (Sign upon printing):

Date (MM/DD/YYYY):

