

**BLUE RIDGE PEDIATRIC & ADOLESCENT MEDICINE, INC
ELECTRONIC MEDICAL RECORDS SIGNATURES**

Child's Name _____ **Date of birth** _____

Parent/Guardian name _____

CONSENT TO TREAT

I give permission for the physicians of Blue Ridge Pediatric & Adolescent Medicine, Inc., or persons designated by them to interview, examine and perform necessary tests and provide treatment to the above named minor. Permission for evaluation and treatment is granted whether the child is presented by parent, other family member, unrelated person or unaccompanied.

FINANCIAL POLICY

I acknowledged that I have received a copy of the Financial Policy. I further authorize my insurance benefits to be paid directly to Blue Ridge Pediatric & Adolescent Medicine, Inc., realizing that I am responsible to pay any and all copays, deductibles, and non-covered services.

HIPAA

I acknowledge that I have received a copy of the Notice of Information Practices.

DESIGNATED INDIVIDUALS AUTHORIZATION

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my child's treatment, payment or administration operations related to treatment and payment. I understand that the identity of the designated parties must be verified prior to the release of any information.

Name _____ Relationship to child _____

Name _____ Relationship to child _____

Name _____ Relationship to child _____

Name _____ Relationship to child _____

Print Name Relationship

Signature Date