CONSENT FORM

Treatment and Assignment of Benefits

Commonwealth Pediatrics

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Consent for medical treatment

I allow the healthcare providers of Commonwealth Pediatrics to give the patient named below medical care, including medical examinations, diagnostic testing or procedures, administration of medications, treatments, and other medical services as determined by the provider. I understand that, absent emergency circumstances, major therapeutic and diagnostic procedures will not be performed unless I have had the opportunity to discuss such procedures and the risks associated therein to my satisfaction, and I have consented to such procedure. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made to me promising any specific result or outcome. I understand that various Commonwealth Pediatrics providers may use a HIPAA compliant virtual medical scribing service that will assist in documenting the patient visit through secure real time encounters.

Release of information for payment and assignment of benefits

I agree that Commonwealth Pediatrics can share the patient's health information with the patient's health plan or other payment source in order to receive payment for services rendered. I hereby assign to Commonwealth Pediatrics the right to health insurance benefits otherwise payable to me or the patient on account of the care provided, and I authorize such medical insurance benefits to be paid directly to Commonwealth Pediatrics. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. A copy of this assignment and authorization may be used in place of the original.

Acknowledgement

This approval will remain in effect until:

1. the patient turns 18, or

2. the patient leaves Commonwealth Pediatrics.

Patient's name: _____

Date of birth: _____

Patient's signature (if over 18): _____

Parent/Guardian name: _____

Relationship to patient: _____

Parent/Guardian signature: _____

Today's date: _____