



Consent to Treat/Acknowledgement of Financial Responsibility

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. Authority is granted to Health First Physicians to render needed treatment and/or tests to the patient.
2. I authorize Health First Physicians to release any information required for payment of insurance claims.
3. I authorize my insurance or Medicare benefits to be paid directly to the treating physician, realizing I am responsible to pay non-covered and unauthorized services.
4. I understand that I am responsible for all charges incurred through Health First Physicians. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.
5. I have been given Health First Physician's handout on missed appointments and understand my responsibilities regarding being late or absent.
6. Parent or legal guardian consent must be provided for treatment of a child (under the age of 18) for every visit. If you are unable to accompany your child to each visit, you may designate specific person(s) (adults over age 18) below as giving consent to treat for your child on your behalf.

Name _____ Relation to child _____

Name _____ Relation to child _____

Preventive Visits and Immunizations

Preventive visits are an opportunity to provide education on your child(ren)'s growth and development as well as directly address all of your concerns. Many times important details may not be available from caregivers, older siblings or grandparents. Also, during these preventive care visits, important immunizations are administered. It is vitally important that you understand the risks and benefits of each immunization by reviewing a vaccine information sheet for each vaccine given. **As physicians, we would PREFER that the parent or legal guardian be present for these visits.**

7. In the event of an emergency, I designate the following person as my emergency contact:

Name _____ Home phone _____

Address _____ Other phone _____

City/State/ Zip _____

8. Expirations or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

Signature of Patient or Legal Guardian

(Date)