



## General Consent Form

### Consent to Treat

I consent to, and authorize the physicians, nurses, and other healthcare providers at Sandhill Pediatrics PA to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

### Assignment of Benefits/Payments for Services

I authorize payment of any and all benefits to Sandhill Pediatrics PA. I know that I must pay for any charges for my care or that of my dependents that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with Sandhill Pediatrics PA to get payment for my care. If I am eligible for payment from more than one type of coverage, Sandhill Pediatrics PA will return any extra payments to the payor. If I have an unpaid bill at Sandhill Pediatrics PA, any refunds due to me will be put on my unpaid bill. If there is money left over after my bill is paid, I will get a refund from Sandhill Pediatrics PA.

### Other Individuals Authorized to Consent to Treatment

In addition to the legal guardians of the patient, the following persons are authorized to consent to any recommended medical care for my child: (e.g. grandparents, nanny, siblings over the age of 18 years, etc):

Name:	Relationship to child:
1. [_____]	[_____]
2. [_____]	[_____]
3. [_____]	[_____]

My signature here means I have read this information and understand it. This consent is valid until revoked in writing.

Patient Name: [\_\_\_\_\_] Date of Birth: [\_\_\_\_\_]

Signature: [\_\_\_\_\_] Date: [\_\_\_\_\_]

Print Name: [ \_\_\_\_\_ ] Relationship to Patient: [ \_\_\_\_\_ ]