Lehigh Valley Peds

CONSENT TO TREATMENT
RECORD RELEASE
& PAYMENT AUTHORIZATION FORM

CONSENT TO TREATMENT

I hereby consent for my child to receive treatment by the physicians or designates of Lehigh Valley Pediatric Associates, Inc. I also consent for treatment for my child should he/she be presented by a representative of my family, guardian, babysitter, etc. at the time of the appointed visit.

RECORD INFORMATION RELEASE

I AUTHORIZE Lehigh Valley Pediatric Associates, Inc. to release any/or all records to those individuals or organizations designated appropriate for acceptance and utilization of such information for my child.

PAYMENT AUTHORIZATION

I hereby authorize my medical insurance to make payment directly to Lehigh Valley Pediatric Associates, Inc. I hereby affirm that all payments made directly to me for services provided by Lehigh Valley Pediatric Associates, Inc. will be forwarded to their office upon receipt.

I understand I am financially responsible for all charges not covered by my insurance carrier for the care and treatment of my child.

Signature of Parent/Guardian of Minor Child _____ Date _____

Patient Name _____ Date of Birth _____