HEALTH STAR PEDIATRICS, LLC

GENERAL CONSENT
FOR MEDICAL CARE

Date:_____

SECTION A: PATIENT INFORMATION

Patient Name:_____ Date of Birth_____ Soc Sec#:_____

Parent Name: _____ Date of Birth_____ Soc Sec#:_____

SECTION B: GENERAL CONSENT TO TREATMENT

I do hereby authorize Health Star Pediatrics, LLC and the assistant/s that is designated to perform the treatment/procedure(s) that are reasonable, necessary, and advisable. I have been informed of the reasons for the treatment/procedure(s), along with the expected benefits, risk, and possible consequences involved.

Understanding this, I authorize Health Star Pediatrics, LLC to perform such examinations, treatment, laboratory tests, and to administer such medications as, in their opinion, is necessary or advisable for my son/daughter whose name appears above. I understand I may withdraw my consent, at any time, to the extent permitted by law.

SECTION C: INSURANCE AUTHORIZATION

I hereby authorize direct payment of medical benefits to Health Star Pediatrics, LLC for services rendered by them in person or under doctor's supervision. I understand that I am financially responsible for any balance not covered by my insurance, including co-insurance amounts, deductibles and copays.
***These amounts are due upon receipt of the bill and will be transferred to a collection agency after all collections efforts are exhausted.** Commercial insurance and Medicaid: I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits
be made on my behalf.

SECTION D: CONSENT FOR USE AND DISCLOSURE

I have been offered a copy of and have had full opportunity to read and consider your Notice of Privacy Practices. This Notice provides a description of our treatment, payment activities and healthcare operation, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information as described on the Notice of Privacy to carry out treatment, payment activities and healthcare operations.

SIGNATURE:

Signature of Parent, Guardian or personal Representative:_____

Printed Name of Parent, Guardian or Personal Representative:_____

Relationship to Patient:_____ Witness:_____