

Releases and Authorizations

Patient Name _____

I hereby assign medical benefits due to me to be paid directly to Children's Clinic East, P.C. I hereby consent to the release of medical information necessary to process any insurance claims and to any other doctor for the continuation of my medical care. I understand that a photocopy of this release is as valid as the original.

X _____

X _____

Signature of Parent or Guardian

Date

I understand that I am fully responsible for payment in full for any services rendered by Children's Clinic East not covered by insurance benefits. In the event this account is turned over to collections to protect the interests of Children's Clinic East I understand that I will also incur the cost of said collection, which include reasonable attorney fees and court costs.

X _____

X _____

Signature of Parent or Guardian

Date

I hereby give permission to the physicians, physician assistants and nurse practioners of the Children's Clinic East to perform emergency/urgent surgical, medical or diagnostic procedures necessary to treat my child for his/her condition.

This permission is primarily for use in emergent/urgent situations. I understand that I or another responsible and knowledgeable adult should accompany my child for routine care.

This permission slip will be used in addition to making an effort to contact parents or legal guardians.

X _____

X _____

Signature of Parent or Guardian

Date

X _____

Relationship to Patient

Below to be completed by Office Staff

Witness

Date