**Platte County Pediatrics**

**General Consent for Treatment**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date of Birth**: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

**General Consent for Treatment**I request and authorize health care services by my provider and his/her designee(s) as my provider may deem advisable and in my best interest. This may include routine laboratory, procedures and medication administration.  
I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give informed consent for that procedure. Informed consent means the medical provider must disclose information to me including expected benefits and risks of a particular procedure and/or treatment. This understanding includes that no research or experimental procedures may be done without my knowledge and consent. **Release of Medical Information**This form has been fully explained to me, and I understand its content and significance. I consent to Platte County Pediatrics use of my health information related to the medical services provided for the following purposes: my treatment, obtaining payment for the medical services and for health care operations of Platte County Pediatrics or other treating providers, all as permitted under federal and state laws and regulations.  
**Payment**I assign and authorize payment, for any and all services rendered, directly to Platte County Pediatrics from my insurance company and or third party payer including, but not limited to, Medicare, commercial health insurance, and automobile no-fault insurance.   
I agree to pay any balance due for services provided. Payment is due within 30 days. If payment is not made by due date late service fees will be applied. If account becomes delinquent I agree to pay all costs of collection.   
**Effective Jan 1 of 2024**,  
A $2 credit card processing fee will be applied to all credit card payments made for services provided by Platte County Pediatrics.   
**Late Arrival Policy** If you are more than 15 minutes late for your scheduled appointment, you may be required to reschedule. This helps us maintain a timely schedule for the benefit of all patients.  
**No-Show Policy**In the event of three no-shows for appointments within a year, you may be subject to dismissal from the clinic. This policy is in place to optimize appointment availability for all our patients.

**I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents.**

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**Signature of Parent or Legal Representative Date of Signature**

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**Relationship to Patient**