



305 Sunrise Center  
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### **Consent To Treat Minor**

Name of child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby give consent to SonRise Pediatrics & Wellness to perform any radiology or lab testing, examination, anesthetic, medical, or surgical diagnosis, vaccinations or treatment and hospital care as deemed advisable by a licensed physician, nurse practitioner or physician assistant, as well as any assistant on the staff of SonRise Pediatrics & Wellness.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required.

This consent is given to any and all such diagnoses, treatments and hospital care which a licensed physician at SonRise Pediatrics & Wellness recommends.

### **Assignment of Benefits**

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to SonRise Pediatrics & Wellness for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

### **Authorization to Release Information**

I hereby authorize SonRise Pediatrics & Wellness to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from SonRise Pediatrics & Wellness on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Signed: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please specify relationship to minor:  Parent with legal custody  Guardian with legal custody