PATIENT NAME: _____

DATE OF BIRTH: _____

Horizon Pediatrics, PC Conditions of Registration

Medical Consent: I consent to the provision of health care service at Horizon Pediatrics, PC and request my health care provider to provide any care they think is necessary and consistent with my instruction. I understand the care may include tests, medical examination and treatment. I acknowledge that no guarantee has been made to me as to the results that may be obtained from this examination or treatment. If the healthcare services requested require multiple visits, I consent to all necessary routine treatment ordered by my healthcare provider during each visit. I understand if special procedures are needed, my healthcare provider will discuss this with me and additional consent is required.

Authorization to release information: I have received the notice of privacy practices and agree to them.

I have read and fully understand the above information, have asked questions about anything unclear to me, and I am satisfied with the answers I have received, I understand I can revoke this consent at anytime.

_____ _____/_____

Signature of Patient, Parent, or Guardian Date/ Time

Responsibility for personal property: Horizon Pediatrics, PC is not responsible for my personal items.

Financial Agreement: I agree to pay for services rendered according to Horizon Pediatrics, PC rates and terms. I understand I am responsible for charges not covered by my insurance or other agency, which may include deductible and coinsurance. If the insurance payment is not received within 30 days, the balance in full becomes my responsibility. Accounts are payable in full at time of billing and I may be required to pay interest on any unpaid past due balance. If this account is referred to and agency or attorney for collection, I agree to pay the fees involved.

Assignment of Insurance Benefits: I authorize payment directly to Horizon Pediatrics, PC of all insurance of health plan benefits.

Financial Certification: I certify the information given by me is correct and I have read and consent to the terms of the financial agreement. I am the patient, or I am authorized as the patient's agent or representative to execute the above and accept its terms on behalf of the patient, or I assume individually all financial responsibility below.

_____ _____

Signature of Patient, Parent, or Guardian Date