KidMed
Feel better.

CONSENT TO TREAT

Patient Name: _____ **DOB** _____

By signing below, I (or my authorized representative) hereby voluntarily consent to outpatient care at KidMed encompassing routine diagnostic procedures, examination and medical treatment including (but not limited to) routine laboratory work (such as blood, urine and other studies), heart tracing and administration of medications prescribed by the physicians. I also consent to treatment from nurse practitioner and or physician's assistant during my visit.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff, their assistants including physicians' assistants or their designees as is necessary in the medical staff's judgment.

RELEASE OF INFORMATION: (a) I authorize the clinic to release medical information to third party insurance carriers for the purposes of filing insurance claims related to my (his/her) medical care; (b) I further authorize the release of medical information about treatment here to my (his/her) doctor or any designated by me.

In my absence, I authorize KidMed and staff to evaluate and treat

_____, a minor child, that in his or her judgment, the physician/NP/PA determines advisable for the child's well-being.

Please try to contact us regarding the health care of our child at the following number(s):

Parent/Guardian Name _____ Phone _____ Relationship_____

Parent/Guardian Name _____ Phone _____ Relationship _____

Other _____ Phone _____ Relationship_____

Note: If any special parental or custodial relationship exists (such as if the child has one parent only or if guardians hold legal custody in the absence of both parents), please explain the situation below, along with your signature, printed name, and a contact phone number.

Parent or Guardian Name _____

Relationship to Patient _____

Parent or Guardian Signature _____ Date _____

Witness Signature _____ Date _____

*Witness Signature _____ Date _____

* If parent or guardian is giving verbal authorization over the telephone, you should document a second witness.

ASSIGNMENT OF BENEFITS

Patient Name: _____ DOB_____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the KidMed, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to KidMed any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under health care reform legislation, ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____
Patient Signature

_____
Date