BRENTWOOD PEDIATRICS
1600 SOUTH BRENTWOOD, SUITE 100
ST LOUIS, MO 63144

Patient Names: **Date of Birth:**

_____ _____

_____ _____

_____ _____

CONSENT FOR TREATMENT: Welcome to Brentwood Pediatrics! We look forward to assisting you with your healthcare goals. Brentwood Pediatrics, PC, is a private office that is dedicated to providing proactive, patient centered care to the children and families we serve. By signing our treatment consent you are authorizing the physicians and personnel of Brentwood Pediatrics to conduct physical examinations and routine services, order and perform tests and administer treatment deemed necessary by the examining physician. Should treatment be performed, the physician will fully inform you as to the nature of the procedure, the alternatives to treatment and the risks involved. You will be given the opportunity to ask questions and have your questions answered.

TREATMENT OF MINOR CHILDREN: (If applicable) I am the legal guardian of the above named child/children. I understand that I should accompany my child to all office visits and agree to make every effort to be present whenever my child is in need of medical services. On those occasions, when it is impossible for me to accompany my child, I designate the following people as authorized to act on my behalf with regard to making decisions for my child during the visit.

Adult's Name: _____ Relationship: _____ Adult's Name: _____ Relationship: _____

CONFIDENTIALITY: I have received a copy of Brentwood Pediatrics Notice of Privacy Practices brochure which describes rights and duties regarding the use and disclosure of medical information.

FINANCIAL RESPONSIBILITY: I am responsible and liable for all charges incurred, even if I am not the insurance subscriber. I agree to pay in full at the time of visit for any copay or non-covered services. I agree to pay in full for any charges applied to deductible, co-insurance amount due or other balances not paid by insurance. I authorize the release to my insurance company any medical information necessary to process a claim and hereby assign payment of all medical benefits to Brentwood Pediatrics.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AM CONSENTING TO TREATMENT AT BRENTWOOD PEDIATRICS.

_____ _____ _____

Signature of parent or guardian or Signature of patient (18 and over) **Relationship to patient** **Date**