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BLUE RIDGE PEDIATRICS
Professional, Personalized Care for Newborns, Children & Adolescents

NORTH PARK OFFICE PARK
457-B HWY 123 BYPASS
SENECA, SC 29678

AUTHORZATION AND CONSENT FOR MEDICAL TREATMENT, PAYMENT GUARANTEE, AND NOTICE OF PRIVACY PRACTICES

- **CONSENT FOR MEDICAL TREATMENT:** As a patient of Blue Ridge Pediatrics, LLC, I understand that the office has an obligation to provide screening and emergency medical treatment when appropriate and to provide appropriate care and treatment of all patients. I hereby authorize the Physician(s) and/or Midlevel Practitioner in charge of my case to administer any and all necessary or advisable treatments as may be deemed necessary or advisable in the diagnosis and treatment of any condition of my children.

- **PAYMENT GUARANTEE:** I/we agree to pay the established rates of the clinic for all services rendered for the patient named below.

- **RELEASE OF MEDICAL INFORMATION:** I do hereby authorize the office Blue Ridge Pediatrics, LLC, to release medical or other information about me or my child(ren) to any insurance companies involved or any other agency assisting in the payment for the patient's care.

- **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT:** By signing this form, you acknowledge receipt of the notice of privacy practices of Blue Ridge Pediatrics, LLC. Our notice of privacy provides information about how we may use and disclose your protected health information. We are required by federal law to obtain your acknowledgement that you have received this Notice. If you have any questions about our notice of privacy practices, please contact us at the above telephone number.

THE UNDERSIGNED CERTIFIES HE/SHE HAS READ AND UNDERSTANDS THE ABOVE INFORMATION/AUTHORZATION. IT ALSO CERTIFIES YOU HAVE RECEIVED OUR NOTICE OF PRIVACY PRACTICES.

Patient Name:_____ DOB: _____

Parent/Guardian Signature: _____ Date: _____