

# Consent of Treatment

South East Bay Pediatric Medical Group  
2191 Mowry Ave., Ste. 600C, Fremont CA 94538  
Ph. (510) 792-4373 Fax (510) 792-3420

Patient Name: \_\_\_\_\_

## CONSENT FOR TREATMENT OF A MINOR:

I authorize the physicians of South East Bay Pediatric Medical Group, Inc. to perform on my child any necessary or routine medical or surgical treatments, including examination, injections, immunizations, and/or diagnostic procedures, including radiologic studies and/or laboratory analysis. I understand that in unusual circumstances efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached.

This authorization will remain in effect unless so designated in writing that such consent for treatment of a minor is rescinded.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent Name: \_\_\_\_\_  
                   mother       father       other \_\_\_\_\_

## AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the physicians at South East Bay Pediatric Medical Group, Inc. to release any information acquired in the course of my child's examination or treatment to insurance companies or others as designated by me.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly to the physicians at South East Bay Pediatric Medical Group, Inc. for the surgical and/or medical services provided.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ACKNOWLEDGEMENT OF MISSED APPOINTMENT POLICY:

I agree to cancel any scheduled appointment for my child that I do not plan to keep. I understand that failure to do so will result in an additional charge. I understand that at least 24 hours prior notification is required.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ACKNOWLEDGEMENT OF TELEPHONE ADVICE POLICY:

I understand that there will be a charge for telephone advice provided outside of normal clinic hours. I understand that I am responsible for payment of this charge if said service is not a covered benefit of my insurance plan.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_