Total Access

Pediatric Urgent Care

Consent for Treatment

I hereby give my permission for Total Access Pediatric Urgent Care LLC to treat my child, _____ (Please Print), according to the standards of care defined by the American Association of Pediatrics (AAP) and to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

Assignment of Benefits/Payment for Services

I authorize payment of any and all benefits to Total Access Pediatric Urgent Care LLC. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with Total Access Pediatric Urgent Care to get payment for my care. If I am eligible for payment from more than one type of coverage, Total Access Pediatric Urgent Care will return any extra payments to the payor. If I have an unpaid bill at Total Access Pediatric Urgent Care, any refunds due to me will be put on my unpaid bill. If there is money left over after my bill is paid, I will get a refund.

Print Name _____

Signature _____

Date _____