

Consent to Treatment and Use of Health Information



Post Road Pediatrics
Boston Children's
Primary Care Alliance

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Consent for Medical Treatment

I allow the healthcare providers of Post Road Pediatrics, LLP to provide me / my child with medical care, including medical examinations, diagnostic testing or procedures, administration of medications, treatment, and other medical services as determined by the provider. I understand that absent emergency circumstances, major therapeutic and diagnostic procedures will not be performed unless I have had the opportunity to discuss such procedures and the risks associated therewith to my satisfaction and I have consented to such procedure. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made to me promising any specific result or outcome.

Release of information for payment and assignment of benefits

I agree that Post Road Pediatrics, LLP can share the patient's health information with the patient's health plan or other payment source in order to receive payment for services rendered. I hereby assign to Post Road Pediatrics, LLP the right to health insurance benefits otherwise payable to me or the patient on account of the care provided, and I authorize such medical insurance benefits to be paid directly to Post Road Pediatrics, LLP. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. A copy of this assignment and authorization may be used in place of the original.

Acknowledgment

This approval will remain in effect until the patient leaves Post Road Pediatrics, LLP.

Patient's name: _____

Parent/Legal guardian's name (if applicable):

Signature of parent/legal guardian/self (if 13+):

Relationship to patient: _____

Date: _____