Pediatric Associates of Hampden County

Consent to Treatment and Use of Health Information

Consent for Medical Treatment

I allow the healthcare providers of **Pediatric Associates of Hampden County, Inc.** to give the patient named below 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 **Pediatric Associates of Hampden County, Inc.** 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 **Pediatric Associates of Hampden County, Inc.** 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 **Pediatric Associates of Hampden County, Inc.**.. 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 **Pediatric Associates of Hampden County, Inc**.

_____	_____
Patient's Name	Patient's Date of Birth
_____	_____
Parent/Legal Guardian's Name (if applicable)	Relationship to Patient
_____	_____
Signature of Parent/Legal Guardian/Self (if 18+)	Date