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Palo Verde Pediatrics

PALO VERDE PEDIATRICS MEDICAL TREATMENT AGREEMENT

Patient or the patient's legal representative agrees to the following terms of treatment.

1. **MEDICAL TREATMENT:** The patient consents to the treatment, services and procedures which may be performed in the clinic, which may include multiple visits, and which may include but are not limited to laboratory procedures, X-ray examination, medical and surgical treatment or procedures, anesthesia, or clinic services rendered under the general or specific instructions of the responsible physician or other health care providers. The clinic may establish certain criteria which will automatically trigger the performance of specific tests which patient agrees may be performed without any further separate consent.
2. **GENERAL DUTY NURSING:** The clinic provides only general nursing care.
3. **LEGAL RELATIONSHIP BETWEEN CLINIC AND HEALTH CARE PROVIDERS:** The patient will be treated by his/her attending doctor or health care providers and will be under his/her care and supervision. Some physicians and other health care providers furnishing services to the patient, including radiologist, pathologist, anesthesiologist and the like, may not be Clinic employees and while the services they render are authorized by this consent, they are responsible for their own treatment activities. These providers may bill the patient separately for their services.
4. **MONEY AND VALUABLES:** The clinic will not be responsible for loss or damage to items such as glasses, dentures, hearing aids, contact lenses, jewelry or money.
5. **TEACHING PROGRAM:** The clinic participates in training programs for physicians and health care personnel. Some patient services may be provided by persons in training under the supervision and instruction of doctors or clinic employees. These persons may also observe care given to the patient by doctors and clinic employees. Photos or video tapes may be made of diagnostic and medical/surgical procedures for training purposes.
6. **RELEASE OF INFORMATION:** The clinic or treating provider may disclose all or any part of the patient's medical and/or financial records (INCLUDING INFORMATION REGARDING ALCOHOL OR DRUG ABUSE, HIV RELATED OR OTHER COMMUNICABLE DISEASE RELATED INFORMATION), to the following:
   a. **THIRD PARTIES:** Patient records may be released to health care providers or their agents who are providing or have provided health care to the patient or patient's child; to any individual or agent responsible for payment to the clinic's or other provider's charges; to health care providers or organizations accrediting the facility or conducting utilization review, quality assurance, or peer review; and to the clinic's and provider's legal representatives and professional liability carriers.
   b. **MEDICAL EDUCATION AND RESEARCH:** Information may be reviewed for teaching, study and research purposes. Information may also be released for use without patient-identifying information in medical studies and medical research.

I have read and understand this Treatment Agreement and have received a copy, and I am the patient, the parent of a minor child, or the legal representative of the patient and am authorized to act on the patient's behalf to sign this agreement.

*Signature ☐Patient ☐Parent of Minor Child ☐Court-Appointed Guardian ☐Patient-Appointed Agent ☐Statutory Surrogate (Please check correct title)

Date

Witness

FINANCIAL AGREEMENT

I agree that in return for the services provided to the patient by the clinic and/or other health care providers, I will pay the account of the patient and/or prior to discharge make financial arrangements satisfactory to the clinic and/or any other providers for payment. If an account is sent to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses. The amount of the attorney's fees shall be established by the court and not by a jury in any court action. A delinquent account may be charged interest at the legal rate.

I request that payment of any authorized Medicare benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

If any signer is entitled to benefits of any type whatsoever under any policy of insurance insuring patient, or any other party liable to patient, that benefit is hereby assigned to the clinic and/or to the provider group rendering service for application on patient's bill. HOWEVER, IT IS UNDERSTOOD THAT THE UNDERSIGNED AND PATIENT ARE PRIMARILY RESPONSIBLE FOR PAYMENT OF PATIENT'S BILL.

IN RENDERING TREATMENT, THE CLINIC AND OTHER PROVIDERS ARE RELYING ON MY AGREEMENT TO PAY THE ACCOUNT.

EMERGENCY CARE WILL BE PROVIDED WITHOUT REGARD OF ABILITY TO PAY.

*Signature ☐Patient ☐Parent of Minor Child ☐Court-Appointed Guardian ☐Patient-Appointed Agent ☐Statutory Surrogate (Please check correct title)

Other Party Agreeing to Pay

Witness

*Relationship to Patient

Date