

Northpoint Pediatrics

****PLEASE READ AND INITIAL EACH SECTION AND SIGN AT THE BOTTOM****

Office use only

Child's Name: _____	DOB: _____	Acct #: _____
Child's Name: _____	DOB: _____	Acct #: _____
Child's Name: _____	DOB: _____	Acct #: _____
Child's Name: _____	DOB: _____	Acct #: _____

CONSENT FOR MEDICAL TREATMENT OF A MINOR

I (we) the undersigned legal parent(s) or guardians of stated child(ren), a minor(s), do hereby authorize and consent to any medical exam or treatment rendered under the general or special supervision of any Northpoint Pediatric Physician or Nurse Practitioner, a duly licensed physician or nurse practitioner, licensed under the provisions of the laws in the State of Indiana. It is understood that this authorization is given in advance of any specific diagnosis, recommended treatment or recommended medical care being required but is given to provide authority and power to render care, which the aforementioned physician or nurse practitioner in the exercise of his or her best judgment may deem advisable.

Restrictions: _____

____ initials

FINANCIAL RESPONSIBILITY AGREEMENT

I have received, read and agree to adhere to the Northpoint Pediatrics's Financial Responsibility Agreement Version 2.2.

____ initials

NOTICE OF PRIVACY PRACTICE

I have received and read the Northpoint Pediatric Notice of Privacy Practice.

____ initials

CONSENT FOR COMMUNICATION VIA ELECTRONIC MAIL

I have read and agree to the Northpoint Pediatric consent for communication via electronic mail. Email communication is initiated by parent to Patient Account Department to answer account questions.

____ initials

Email address _____

Legal Parent / Legal Guardian Signature: _____

Printed Name: _____

Relationship to Child: _____ Today's Date: _____

****Office Use Only – Form scanned by _____ Date Scanned _____**
Form entered by _____ Date entered _____
Form received by _____