CONSENT TO TREAT

I give Dr. Gary Halberstadt consent to provide and perform medical care, tests, procedures, and administer medications and vaccines as are considered necessary or beneficial for my child's health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Parent Signature: _____ Date: _____

Authorization to consent for Medical Treatment in my absence:

I hereby grant the following person(s) the authority to bring my child to Broad Ripple Pediatrics for medical care, tests, procedures, and immunizations.

_____
_____ _____ _____

Parent Signature: _____ Date: _____

Electronic Communications

Automated Calls: As an added convenience, we *may* offer automated reminders via a text message or an automated call for those who wish to participate. The reminders are sent from a computer and cannot be used as a way for you to communicate back to us. If you should need to reach us, please call our main number. If at any time you should change your mind, please let us know what other method you would prefer for reminders.

I understand under the telephone consumer protection act, that in order for you to contact me by automated means for services relating to my medical care, including monies I may owe, etc., I agree that Broad Ripple Pediatrics and/or our agents may contact me by my cell phone, which may result in charges to me. You may also contact me by text messages, or e-mails, providing that I have consented below. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device, as applicable.

☐ Yes, I want to participate. My cell phone number is: _____

My e-mail address is: _____

☐ No, I do not wish to participate at this time.

Parent Signature: _____ Date:_____

Release of Protected Health Care Information:

{Unless otherwise stated only the Mother and Father may receive protected health care information.}

I give consent and authorization for the medical, or billing staff of Broad Ripple Pediatrics to discuss protected Health Care Information about my child with the following person(s):

Name_____Relationship_____Phone_____
_____
_____
_____
_____

FINANCIAL RESPONSIBILTY: PLEASE READ CAREFULLY!

By signing below, I confirm that all personal information is correct, and I verify that I have provided the most current/accurate insurance information for my child. If I have failed to provide current information and the medical claim is denied, I understand that I could be responsible for payment in full for all services and/or for a $25.00 fee to re-file to the correct insurance company. I acknowledge that I have read and understand the Financial Payment Policy for Broad Ripple Pediatrics and have been offered a copy. I understand that if I do not pay my balance in a timely manner, I may be subject to a collections filing fee of $25.00 and/or $20 finance charge. I authorize the release of any information regarding my child's exam and treatment for the purpose of obtaining insurance compensation, pre-certification or medical records. I authorize payment of medical benefits for services rendered by Dr. Gary Halberstadt.

Parent Signature Date Parent Signature Date

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

1/2018 For Office Use Only :_____ Entered by: _____