Fellsway Pediatrics
Boston Children's
Primary Care Alliance

fellswaypediatrics.com
781-665-4364

Consent for Treatment

Patient name: _____

HIPAA Notice of Privacy

By signing below, I acknowledge that I have been provided on request a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed, and how I may obtain access to and control of this information.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this medical group, its staff, and its business associates.

Parent signature: _____

Date: _____

Physician Office Consent for Treatment

I, being the parent or guardian, do hereby request and authorize the medical staff to perform necessary medical services for my child, which are deemed advisable by the doctor, whether or not I am present at the actual appointment when treatment is rendered.

Parent signature: _____

Date: _____

Physician Office Financial Release of Information

I understand that I am financially responsible for all charges whether or not they are paid by the insurance company. I authorize the use of this signature on all submissions whether manual or electronic.

Parent signature: _____

Date: _____