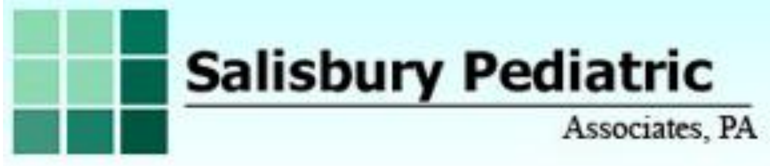

Consent for Treatment and Agreement to Pay:

The undersigned, whether signed as the patient or responsible party for the patient, consents to examination and treatment of ____. The patient has the right to treatment, including access to medical care and habilitation, regardless of age or degree of mental health or intellectual or developmental disabilities.

I understand that the practice of medicine and surgery is not exact science. I understand that no guarantees have been made to me as the result of examination or treatment in this medical center. I understand that (a) it is customary that no substantial procedure be performed upon a patient unless this procedure has been discussed with legal responsible party, (b) Parent or legal guardian has the right to refuse treatment to any proposed procedure or therapeutic course, (c) No patient will be involved in any research or experimental procedure without consent of legal guardian. When my child (or self if 18 years of age) is treated at Salisbury Pediatric Associates, P.A., I hereby voluntarily consent to routine care, diagnostic procedures and medical treatment that is necessary for my child (or self if 18 years of age).

Financial Responsibilities:

In consideration of medical services rendered or to be rendered by Salisbury Pediatric Associates, P.A. in Salisbury, NC and the physician, the undersigned does hereby guarantee payment to Salisbury Pediatric Associates, P.A. Payment is due on demand of all charges for said services and incidentals incurred on behalf of the treatment to my child (or self if 18 years of age). In the event of nonpayment, the undersigned is subject to insurance contractual obligations and, additionally, guarantees payment of all costs of collection, including reasonable attorney fees.

Assignment of Insurance Benefits:

I hereby assign payment directly to Salisbury Pediatric Associates, P.A. for regular charges for this period of treatment. It is further agreed that any credit balance resulting from payment of the insurance or other sources may be applied on any other child's account that is owed to Salisbury Pediatric Associates, P.A. by the insured family. I hereby assign payment to Salisbury Pediatric Associates, P.A., directly, from the insurance benefits herein specified and otherwise payable to me for the purpose of satisfying the physician's account or any other account of said physician's office for whom I am responsible, but payment is not to exceed the physician's regular charges for this period of treatment. I authorize refund of overpaid insurance benefits in accordance with my insurance policy conditions where by coverages are subject to coordination of benefit clause.

I understand I am financially responsible to Salisbury Pediatric Associates, P.A. for charges not covered by this authorization.

Consent to Auto-Dial Cell phones:

I give Salisbury Pediatric Associates, P.A. permission to auto-dial my primary or cell phone for appointment reminders, inclement weather cancellations, and collections calls, if applicable.

______________________________	______________________________
Patient's Name	Responsible Party (ies) Name
______________________________	______________________________
Witness	Relationship to Patient