Lake Country PEDIATRICS, S.C.
independent . integrated . dedicated

Third Party Consent to Treat

I, _____ ,parent/ legal guardian of _____,
Name / Date of Birth

give permission for _____/_____,
Name of person(s) / Relationship to Patient

to accompany my child to Lake Country Pediatrics, S.C. for medical care.

This authorization is given in advance of any specific diagnosis or care being required. I authorize this person(s) to consent to any x-ray examination, medical diagnosis, prescription, care, or treatment which is recommended by and/or rendered under the general or special supervision of any licensed medical provider of Lake Country Pediatrics S.C.

If third party is authorized to consent to routine shots (allergy shots, antibiotic shots, and vaccines), please initial here: _____

If there are any exceptions, please list them here:

This authorization shall remain effective until _____ turns 18 years of age,
(child's name)
or this document is revoked in writing, whichever occurs first.

In case of emergency, please contact me at _____.

Parent/Guardian Signature _____ Date _____

970 S. Silver Lake St. Ste 102
Oconomowoc, WI 53066
Ph: (262)569-7100 Fax: (262)567-6295

2574 Sun Valley Dr. Ste 207
Delafield, WI 53018
Ph: (262)646-2282 Fax: (262)646-7535

General Consent for Admission / Treatment

General Consent and Agreement to Pay for Treatment

1. Consent for Treatment: I am entering Lake County Pediatrics, SC (the "Facility") for medical care and treatment. I consent to my physician, other attending, consulting and/or referring physicians and their assistants, and other Facility personnel, providing me with all medical, diagnostic or other treatment services judged necessary and/or appropriate. This includes all tests, x-rays and laboratory procedures, treatments, medications monitoring and blood transfusions that do not require my separate and specific informed consent. I understand that my doctor or my doctor's designee will discuss my care and treatment options with me. I know I can refuse to consent to any procedure or treatment.

2. General Acknowledgments: I understand that the practice of medicine and surgery is not an exact science. No promise of cure or outcome of treatment has been made to me. I understand that many of the physicians who care for me in this Facility are not employees or agents of the Facility but are allowed by the Facility to provide for the care and treatment of their patients. I understand that the Facility is not liable for any acts or omissions of, or the instructions given by, such independent contractors who treat me at the Facility. I understand that it is my responsibility to follow the instructions of my care providers and to make arrangements for follow up care. I understand that in the course of diagnosis and treatment, cells, tissues and/or parts may be removed from my body. I authorize Facility personnel to preserve or use such cells, tissues, or parts for teaching purposes and/or dispose of any cells, tissues or parts that are removed.

3. Students: I know that the Facility has agreements with education organizations. I know that students may provide care and/or observe my care. Any care I receive from students will be under the supervision of my physician and/or Facility staff.

4. Valuables: Keeping valuables in the above named Facility is strongly discouraged. I understand that the Facility has a place where my valuables can be stored. If I choose to keep my valuables with me, I do so at my own risk and the Facility is not responsible for any loss or damage to my valuables.

5. Medical Records: I understand my healthcare information will be stored, viewed and shared by my health care providers in one secure electronic medical record system. Once all my providers document my treatments and services in this shared record, I understand it cannot be separated. I agree that my medical records may be shared with my insurance carrier or its agents to obtain pre-authorization for care and to support payment of my claims or bills. This release of records may include information related to drug/alcohol abuse, mental illness, HIV and developmental disabilities. I understand my information may also be shared for collection purposes. In all cases where my medical records are released, I understand that the Facility will only share what is necessary.

6. Insurance Benefits/Agreement to Pay: I agree to pay for all charges that are due because of my care and treatment at the above named facility. I understand that my care and treatment may require labs or other diagnostics that are under the supervision of an independent physician who may bill separately. I hereby assign to Facility and the physicians and professionals associated with the facility, for application to my bill for services, all my rights and claims for reimbursement under any federal or state healthcare plan (including but not limited to Medicare or Medicaid), Insurance policy, any managed care arrangement or any other similar third party arrangement that covers health care costs for which payment may be available to cover the cost of the services provided to me. I understand that if I choose to have my insurance billed, it is my responsibility to ensure that the rendered service is covered by my insurance carrier. I understand that it is possible my insurance will not pay for the services. Reasons which insurance companies give for not paying for services may include, but are not necessarily limited to: non-coverage, medical necessity, no authorization, services that are deemed experimental, and otherwise based on the limits of the agreement between the insured and the insurance company. I understand that if my insurance company refuses to pay for the services, regardless of the reason my insurance company gives for that refusal, I will be responsible for payment of these services. If my account becomes delinquent, I understand that, if and as permitted by applicable Federal and state law, the Facility will access my credit file, place my account with a collection agency for further collection activity (including access to my credit file), and may assess interest to my account. An automated dialer system may be used to make outbound phone calls to the phone numbers on record for collection purposes.

7. Medicare and Medicaid Patients: All the information I gave when I applied for Medicare/Medicaid payment is correct. I request that payment of authorized Medicare benefits be made on my behalf to the above named Facility for any services furnished to me by them. I authorize any holder of medical information about me to release to The Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

8. Photographing: I understand that the Facility may take photographic and/or video images of me in cases when it may assist with my treatment.

9. Home Health and Hospice: Even at the time of admission/registration, it is important to start considering and planning for post-discharge care. I understand that I have the freedom to choose and the right to select my provider for any post-discharge care I might need. I am aware that for home health care and hospice services, after discharge, the hospital will generally use ProHealth Home Care and Hospice, unless I select a different provider. I understand that a list of other available home care and hospice agencies is available to me upon request.

I HAVE READ THE ABOVE. I AGREE WITH ITS CONTENTS.

Date: _____ _____ _____ at _____ a.m. / p.m.
Month Day Year Time

Signature_____ Date_____ Time_____
Patient

Witness_____ Date_____ Time_____

If the patient is a minor or unable to consent, complete and sign the following. Patient is unable to sign because:

_____

_____

Signature_____ Date_____ Time_____
Patient's Personal Representative signing on behalf of the patient

Relationship to Patient_____

Witness_____ Date_____ Time_____