

The Doctors Luce Pediatrics, LLC Patient Consent Form

(Please Print Patient/Responsible Party Name On Underscore, Read and Sign)

I, _____, hereby consent to the following Treatment:
OR, If Minor, I, _____, hereby consent to the following Treatment
as responsible party for patient named _____.

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **The Doctors Luce Pediatrics, LLC** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **The Doctors Luce Pediatrics, LLC** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **The Doctors Luce Pediatrics, LLC**.

I understand it is my responsibility to pay any CO-PAY, DEDUCTIBLE, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PARTY PAYOR WITHIN A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS.

Patient/Responsible Party Initial: _____

I acknowledge that I have been given the **The Doctors Luce Pediatrics, LLC**. Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. **Patient/Responsible Party Initial:** _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (or Responsible Party) Signature & Date