Consent to Treat

My child is a patient of Dr. Jami Knox at Aloha Pediatrics. By signing this consent form, I give consent for my child to be treated by the physician and staff of this practice. I understand that treatment and services may include:

- Lab tests,
- Screening tests (tests that can find an illness early, before a person shows signs of having the disease),
- Diagnostic tests (tests that show if a person has a certain illness or health problem), and
- Routine exams.

My doctor may need to photograph or videotape my child to learn more about their health problem.

I understand that no promises have been made to me or my child about the results of any treatment or services.

Assignment of Benefits

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Aloha Pediatrics LLC and/or Dr. Jami Knox for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Dr. Jami Knox and Aloha Pediatrics LLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Jami Knox and/or Aloha Pediatrics LLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Printed Patient Name Date

_____ _____

Guarantor Name (if different from patient) Relationship to Patient

_____

Signature of Guarantor