Camelback Pediatrics, PC

PATIENT INFORMATION FORM

Please Complete This Entire Form (list all children the information applies to)

PLEASE PROVIDE A COPY OF ANY DOCUMENTS RELATED TO CUSTODIAL RIGHTS FOR THE PATIENT'S RECORD

PATIENT LAST NAME: GENDER: ☐ *M* ☐ *F* ☐ *Other*	PATIENT FIRST NAME:	MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME: GENDER: ☐ *M* ☐ *F* ☐ *Other*	PATIENT FIRST NAME:	MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME: GENDER: ☐ *M* ☐ *F* ☐ *Other*	PATIENT FIRST NAME:	MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME: GENDER: ☐ *M* ☐ *F* ☐ *Other*	PATIENT FIRST NAME:	MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME: GENDER: ☐ *M* ☐ *F* ☐ *Other*	PATIENT FIRST NAME:	MIDDLE INITIAL:	PATIENT DATE OF BIRTH:

MAILING ADDRESS:	CITY:	STATE:	ZIP:
PHYSICAL ADDRESS *(If different)*:	CITY:	STATE:	ZIP:

PRIMARY PHONE: ( )	CELL PHONE: ☐ *Check if same as Primary* ( )	WORK PHONE: ( )	EXTENSION:

E-MAIL ADDRESS:	ENABLE FOR PATIENT PORTAL: ☐ Yes ☐ No ☐ Not Applicable
PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Other Language *(Please specify)*:	ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined to Specify

RACE: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Hawaiian Native/ Pacific Islander ☐ White ☐ Declined to Specify ☐ Other (Details) ______________________________

GUARANTOR INFORMATION

(Individual responsible for bills and payment – If you are an 18+ year old patient, this would be YOUR name)

GUARANTOR LAST NAME:	GUARANTOR FIRST NAME:	MIDDLE INITIAL:	RELATIONSHIP TO PATIENT *(Check all that apply)*: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Legal Guardian ☐ Self ☐ Other *(Specify):*
STREET ADDRESS: ☐ *Check if same as patient*	CITY:	STATE:	ZIP
PRIMARY PHONE: ( )	CELL PHONE: ☐ *Check if same as Primary* ( )	WORK PHONE: ( )	EXTENSION:
E-MAIL ADDRESS: ☐ None	SOCIAL SECURITY #:	DATE OF BIRTH *(mm/dd/yyyy)*:	
GENDER: ☐ Male ☐ Female ☐ Other	EMPLOYER NAME:	EMPLOYER PHONE #: ( )	
OCCUPATION:	*Receive Statements via:* ☐ Mail ☐ Email	MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: ☐ Yes ☐ No	

OTHER PARENT

PARENT LAST NAME:	PARENT FIRST NAME:	MIDDLE INITIAL:	RELATIONSHIP TO PATIENT *(Check all that apply)*: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Legal Guardian ☐ Self ☐ Other *(Specify):*
STREET ADDRESS: ☐ *Check if same as patient*	CITY:	STATE:	ZIP:
PRIMARY PHONE: ( )	CELL PHONE: ☐ *Check if same as Primary* ( )	DATE OF BIRTH *(mm/dd/yyyy)*:	
OCCUPATION:	E-MAIL ADDRESS:	MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: ☐ Yes ☐ No	

*ADDITIONAL CONTACT (OPTIONAL) *DOES NOT GIVE MEDICAL AUTHORITY, NEED PROXY FOR ANY NON- BIOLOGICAL PARENT

CONTACT LAST NAME:	CONTACT FIRST NAME:	RELATIONSHIP TO CHILD *(Check all that apply)*: □ Mother □ Father □ Stepmother □ Stepfather □ Legal Guardian □ Other *(Please specify):*

STREET ADDRESS: □ *Check if same as patient*	CITY:	STATE:	ZIP:

PRIMARY PHONE: ( )	CELL PHONE: □ *Check if same as Primary* ( )	DATE OF BIRTH *(mm/dd/yyyy)*:

OCCUPATION:	E-MAIL ADDRESS:

INSURANCE INFORMATION

(*Please present all current insurance cards to the Front Desk)*

I HAVE INSURANCE: □ Yes □ Yes, but pending, not active, or you're not contracted □ No *(Self Pay)*			
PRIMARY INSURANCE:		SECONDARY INSURANCE:	
SUBSCRIBER:	RELATION TO PT:	SUBSCRIBER:	RELATION TO PT:
Policy ID:	Group ID:	Policy ID:	Group ID:
GENDER: □ Male □ Female □ Other		GENDER: □ Male □ Female □ Other	
DATE OF BIRTH:	SOCIAL SECURITY #:	DATE OF BIRTH:	SOCIAL SECURITY #:

CONFIDENTIAL COMMUNICATION

(*I hereby request to receive confidential communications from Camelback Pediatrics, PC in the following manner)*

PHONE MESSAGES – Please leave messages as follows
(Check All That Apply)

Primary Phone: ☐ Mom ☐ Dad ☐ Both
☐ Self (for 18+ year old patients)
☐ **BRIEF MESSAGE** ☐ **DETAILED MESSAGE**

Cell Phone: ☐ Mom ☐ Dad ☐ Both
☐ Self (for 18+ year old patients)
☐ **BRIEF MESSAGE** ☐ **DETAILED MESSAGE**

APPOINTMENT CONFIRMATIONS/RECALLS

CONTACT: (Check one)
☐ Mom ☐ Dad ☐ Self (for 18+ year old patients)

VIA THE FOLLOWING METHOD: (Check one)
☐ Text message
☐ Home/Cell Phone – automated call
☐ Email address

Telephone. Email Contacts

I hereby consent and agree that: (1) anyone acting on behalf of Camelback Pediatrics, PC (herein known as "CP") may contact me as necessary regarding my account (including for collections purposes or related to insurance coverage); (2) any and all of CP's contacts with me may be made via text message or with an automated dialing and announcing or similar device, and via email; (3) CP may contact me at any telephone number I provide to them, whether a residential, business number, or cellular number; (4) I have an established business relationship with CP and that CP may contact me at the telephone number or email address I provide to them, in any of the ways described above. I understand that, if I accept now, I may change at any time by notifying CP staff. □ **Accept** □ **Decline** **Initials:** _____

Release of Protected Health Information in Emergency Situation

I understand that my protected health information may be released as my physician determines appropriate in an emergency situation.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize Camelback Pediatrics, PC to examine and treat my child when necessary. I also authorize the release of my protected health information, acquired in the course of examination to carry out treatment, payment and heath care operations of my child. I hereby authorize payment directly from my insurance company to the physicians of Camelback Pediatrics, PC for medical treatment(s) provided to my child. I understand that payment in full of my responsible portion is required at the time of visit. If Camelback Pediatrics, PC is not a provider on my insurance, full payment is due on the date of service. If Camelback Pediatrics, PC is a provider on my insurance, then any deductibles, copays, or percentages are due at the time of service. Additionally, should it be necessary to assign my account for collections, it is hereby agreed that I shall pay additional fees up to 35% of the balance due, collection agency charges, attorney's fees, and any other costs.

By signing below, I am acknowledging that I have read and understand the above statements.

_____ _____ _____

Parent, Legal Guardian, or Patient (18 or older) Printed Name **Parent, Legal Guardian, or Patient (18 or older) Signature** **Date Signed**

CAMELBACK PEDIATRICS, P.C.

OFFICE INFORMATION, FINANCIAL AGREEMENT, HIPAA NOTICE

Welcome to Camelback Pediatrics! We are pleased that you have selected us to provide care for your precious family. Our goal at Camelback Pediatrics is to provide you and your child convenient, accessible, and high-quality medical care. Please be sure to visit our website at www.camelbackpediatrics.com for lots of information about our services, as well as resources to help you with your child(s) health issues.

Below are some very important points of information, as well as our Financial Agreement with you. **PLEASE READ IT CAREFULLY, THEN INITIAL AND SIGN ON THE LAST PAGE.**

Appointments: In order for us to assure convenience and accessibility, it is important that our patients arrive timely for their scheduled appointments. Therefore, we ask that **ALL** our patients **arrive 15 minutes early for their appointment** to allow our administrative staff enough time to accomplish all their tasks necessary for your visit prior to your appointment time. We also ask that you ***bring a photo ID, insurance card, and form of payment to each appointment***. We will also scan your photo ID and insurance card into our system to keep on file for future reference. Should you require any paperwork to be completed for your appointment, you can find the forms on our website on the "Forms" page. We will give you an automated confirmation call/text/email 1 – 2 days prior to any appointment you have scheduled with us outside of this window.

Late Arrivals: If you arrive 15 or more minutes late after your scheduled appointment time, we reserve the right to reschedule your appointment. *If you know you are running late, please call our office as soon as you know* you will be late so we can reschedule your appointment time, or ensure the provider would still be able to still see you if you arrive late. Please note the late arrival could include the 15-minute early arrival time expected of all patients.

Cancellations and No Shows: Please provide at least 24 hours advance notice if you wish to reschedule or cancel your appointment that was scheduled at least a day in advance (Example: Well visits or Follow Up appointments). If you scheduled a Same-Day Sick appointment, we ask that you call us to reschedule or cancel at least 3 hours prior to your appointment. This policy allows us to make better use of our available appointments for patients in need of medical care. Failure to cancel your appointment within the listed time period will result in a $30 Late Cancellation fee. If you do not come in for your appointment at all, or come in late to your appointment without calling us to let us know ahead of time, this is considered a "No Show" and would be subject to a $30.00 fee as well. **NOTE:** The Late Cancellation and No Show fees will be applied to your account for **EACH** missed appointment. (e.g., two children scheduled at the same time will be charged $30 each for both missed appointments.) In addition, the parent who called in the late cancellation will be responsible for the Late Cancellation fee. Families with three missed appointments (Late Cancellation or No Show) in a calendar year may result in dismissal from our practice. You will then have to make arrangements to establish with a new doctor.

Wi-Fi: We provide Wi-Fi access for our patients in the office. Access information is located at our Front Desk.

Service Animals: Our policy is that we *only* allow Service Animals into the clinic. Unfortunately, we are not able to accommodate any other type of animal.

Patient Portal: Our patient portal allows you to access information such as demographics, shot record, bill pay, plus request routine well visits or referrals, and self-schedule flu shot appointments (seasonal). You can access our portal by going to our website, then click on the button on top right corner of the page.

Well Visit with other health concerns: Please be advised that if you are scheduled for a routine well visit, but also have health concerns that need to be evaluated at the same time, we are *required by your insurance company to bill your insurance for both the well visit and the evaluation of the services OUTSIDE the scope of a routine physical*. This may also result in your insurance company applying copay/co-insurance/deductible to your payment responsibility for the additional services.

Medical Records: If you should require copies of medical record, please go to our website, on the Forms page, to download the Medical Records Release form. Once we receive the completed form, we will process your request within 3 business days. Please note for divorced/separated parents - both parents have access to the minor child's medical records, unless there is a court order that specifically mandates only one of the parents have the right to authorize medical treatment and release of the minor's medical records. Please be aware there may be a minimum fee of $25 per child associated with any record requests. If we have to obtain records from storage, the fee could be higher.

Divorce/Separation/Custody Arrangements: *Camelback Pediatrics is not a party to any agreement between parents - legal or informal*; therefore, we cannot be responsible for enforcing their terms. We reserve the right to discharge any patient from Camelback Pediatrics if an issue comes between the (divorced/separated) parents which would disrupt our practice in any way. We maintain that divorce, separation, and custody agreements should not enter into the medical care of a child; such matters should remain between the parents.

FINANCIAL AGREEMENT

Payment: If you have a copay, coinsurance, deductible, or are a self-pay visit, please know that ***payment is due at the time of service***. Payment is expected at the time of service by any adult bringing the patient to their appointment, including caregivers. We accept cash, check, Visa, MasterCard, and Discover. We do not accept American Express. We also have a Credit Card on File policy (see attached form). Camelback Pediatrics will not be party to custodial, separation or financial disputes relating to individuals regarding minor children to whom services are provided. **The individual who requests the medical services and/or signs the Financial Agreement is responsible for any balance due.**

If you have a credit balance after your insurance processes, we will refund you the difference. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our Billing Department promptly - option 6, then option 1 from the main menu - to discuss this option. We do offer online bill pay through our patient portal on our website - www.camelbackpediatrics.com.

Returned checks will result in a $40.00 fee that will be posted to your account. We will only accept cash and credit card for payment after a returned check is received. Returned check and other office fees, balances older than 60 days, and failure to pay account balances as promised will be subject to external collection along with additional collection fees, including attorney and other court fees. Your credit record may be investigated to determine your ability to pay your debt.

Insurance: In order to help you receive your maximum insurance allowable benefits, we need your assistance and understanding of our payment policy. We do our best to obtain benefit information from your insurance prior to you coming in for your appointment, but we have limited access due to the multiple plans available by each insurance carrier. Additionally, they advise us

the information they give us is not a guarantee of payment or benefits. **Ultimately, it is your responsibility to understand your coverage and benefits, including if we are in network with your plan, precertification, referral and authorization requirements.** We will, however, assist you to ensure that all plan requirements are met.

We require a copy of your insurance card in order to bill your visit appropriately. If you cannot provide a current insurance card at the time of the visit, you will be responsible for payment in full at the time of service. It is not the responsibility of our office to obtain this information for you. We will be happy to supply you with an accounting of the visit so that you may submit the information to your insurance company for reimbursement.

You will be asked to update your personal and insurance information every 12 months or as information changes because we are required by law to obtain your signed authorization to submit claims to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan.

We will gladly submit fees for your covered medical services to your insurance company. **It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 30 days, or if they deny the claim.**

SATURDAY CLINIC AND FEDERAL HOLIDAYS: Billing rules require us to bill all codes associated with your visit to communicate information to your insurance company. These codes include the charge associated with your office visit during Saturday clinics and any Federal Holiday that we are open (example: Martin Luther King Day, President's Day, etc.). Please be aware some insurances will not cover this charge and will make it patient responsibility.

Not all services are a covered benefit on all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered. **If you have an AHCCCS plan, you will be financially responsible for any remaining balance after your primary insurance processes your claims, as we are not contracted.**

Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. We must emphasize that as medical providers, our relationship is with you, and not your insurance company.

Receipt of Notice of Privacy Practices

I have been offered the HIPAA Notice of Privacy Practices which outlines my privacy rights and how Camelback Pediatrics, PC may use and disclose Protected Health Information about me.

☐ **Yes** ☐ **No** ☐ **Offered but Decline** ***Initials:*** _____

I have read the above Office Information, Financial Agreement, and HIPAA Notice. My signature below acknowledges that I understand and agree to the terms and conditions outlined herein.

_____ _____

Parent/Guardian Name (Please Print) **Parent/Guarantor Signature**

Date: _____

Pediatric Medical History

Child's Full Name: _____ **Nickname:** _____

Date of birth: _____/_____/_____ **Gender:** ☐ M ☐ F **Race/Ethnicity:** _____

Height: _____ **Weight:** _____ **Date of last physical examination:** _____

Name, address, and/or phone of PREVIOUS primary physician:

_____

Name, address, and/or phone of medical specialists:

_____

THESE QUESTIONS APPLY TO JUST THIS PATIENT

Is your child being treated by a physician at this time? ☐ YES ☐NO

Reason _____

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ☐ YES ☐ NO

List name, dose, frequency & date started: _____

Has your child ever had a reaction or allergy to an antibiotic or other medication? ☐ YES ☐ NO

If yes, list: _____

Is your child allergic to latex or anything else such as metals, acrylic, or dye? ☐ YES ☐ NO

If yes, list _____

PAST MEDICAL HISTORY

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line.

Significant problems or specialty care	☐ YES ☐ NO
Any serious injuries or accidents	☐ YES ☐ NO
Any surgeries	☐ YES ☐ NO
Any hospitalizations	☐ YES ☐ NO
Delayed or missing immunizations	☐ YES ☐ NO
Attends daycare	☐ YES ☐ NO
Allergies: Outdoor, indoor, or animal	☐ YES ☐ NO
Allergies: food	☐ YES ☐ NO
Eye conditions or corrective lenses	☐ YES ☐ NO
Recurrent ear infections	☐ YES ☐ NO
Other problems with ears or hearing	☐ YES ☐ NO
Allergic rhinitis or other allergy	☐ YES ☐ NO
Recurrent sinusitis	☐ YES ☐ NO
Recurrent sore throat/tonsillitis	☐ YES ☐ NO
Recurrent croup	☐ YES ☐ NO
Recurrent bronchitis/pneumonia	☐ YES ☐ NO

Asthma, reactive airway disease, bronchiolitis	☐ YES ☐ NO
Heart problem or heart murmur	☐ YES ☐ NO
Newborn/infant feeding issues	☐ YES ☐ NO
Abdominal pain, GERD, or colitis	☐ YES ☐ NO
Constipation requiring doctor visits	☐ YES ☐ NO
Bladder or kidney infection or other urologic problem	☐ YES ☐ NO
Bed-wetting (after 5 years old)	☐ YES ☐ NO
Gynecological problems/menstrual problems	☐ YES ☐ NO
Male genital problems	☐ YES ☐ NO
Sexually active	☐ YES ☐ NO
Recurrent skin rash or eczema	☐ YES ☐ NO
Other chronic skin problems (acne, warts, etc.)	☐ YES ☐ NO
Orthopedic problems	☐ YES ☐ NO
Concussion	☐ YES ☐ NO
Recurrent headaches	☐ YES ☐ NO
Seizures, developmental delays, or other neurological disorder	☐ YES ☐ NO
Autistic spectrum disorder	☐ YES ☐ NO
ADD/ADHD	☐ YES ☐ NO
Psychiatric, behavioral, emotional concerns	☐ YES ☐ NO
Use of alcohol or drugs	☐ YES ☐ NO
Thyroid or other endocrine problems	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO
Anemia, bleeding problem, or blood transfusion	☐ YES ☐ NO
Significant family history (celiac, cholesterol, autoimmune, lazy eye, etc.)	☐ YES ☐ NO
Significant social history	☐ YES ☐ NO
Other infectious illnesses	☐ YES ☐ NO
Chickenpox	☐ YES ☐ NO

Other significant past medical history not listed above_____

_____

Explain your "Yes" answers:_____

_____

_____ _____

Signature of Parent/Guardian **Date**

Patient and Sibling(s) Name (please print):_____

SOCIAL HISTORY

ONLY ONE PER FAMILY -- ANSWER QUESTIONS FOR ALL CHILDREN IN THE FAMILY.

Biological parents live together	☐ YES	☐ NO
Issues with custody of your children	☐ YES	☐ NO
Siblings	☐ YES	☐ NO
Pets	☐ YES	☐ NO
Smokers in the home	☐ YES	☐ NO
Swimming pool at home	☐ YES	☐ NO
Swimming pool with fence	☐ YES	☐ NO
Guns in the home	☐ YES	☐ NO
Guns are locked and kept separate from ammunition	☐ YES	☐ NO

FAMILY HISTORY

	Father	Mother	Brother	Sister	Father's Father (Grandfather)	Father's Mother (Grandmother)	Mother's Father (Grandfather)	Mother's Mother (Grandmother)	Other:_____
Nasal allergy (hay fever)									
Asthma									
Eczema									
High cholesterol									
High blood pressure, stroke									
Heart disease (before 50)									
Heart arrhythmia screen: fainting with exercise, pacemaker before 50, antiarrhythmic medications									
Bleeding disorder									
Anemia									
Celiac disease									
Stomach or intestinal problems (GERD, colitis)									
Liver disease or hepatitis									
Kidney disease									
Bed-wetting (after 10 years old)									
Diabetes (before 50 years old)									
Low thyroid									
Lupus, arthritis, colitis									
Immune problems, HIV, or AIDS									
Epilepsy or convulsions									
Alcohol abuse									
Drug abuse									
Mental illness									
Autism, Asperger's									
Intellectual Disability									
Tuberculosis									
Deafness									
Other genetic illness or family history									

_____ _____

Signature of Parent/Guardian **Date**

Credit Card on File Policy

(*OPTIONAL FORM)*

Parents/Guardians:

We are excited to offer a state-of-the-art program to help manage your healthcare dollars. Similar to hotel and car rental agencies, you are asked for a credit card at the time you check in. We will swipe your card with a card reader, which will encrypt the card information and store it securely in our credit card processing company's database. For your protection, only the last four digits of your card will show in our system. This is an advantage for you, as it makes your checkout experience faster, easier, and more efficient. Plus, you will no longer need to write checks or credit card information on your statement remits then mail them to us. An advantage for us is we will be able to decrease the number of statements we send out. All these advantages combined help us all to keep the cost of healthcare down.

As you may know, some insurance plans require copayments, deductibles, and coinsurance in amounts that are not known to you or us at the time of your visit; they are determined after the claim is processed. We will receive an Explanation of Benefits (EOB) from your insurance plan, the same one you receive from them in the mail. The EOB informs us what your insurance plan paid, what their adjustments are, and any patient responsibility. With our Credit Card on File process, once claims are processed by your insurance company, any remaining balance owed by you will be charged to your credit card. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. If you do not receive an EOB in the mail, please contact your insurance plan to have them send you another copy.

If you don't have a credit card, you are welcome to leave an HSA (Health Savings Account) or Flex Plan card on file.

If you would prefer not to leave any type of card on file, we will ask for payment at time of service with cash, credit card, or check. Any qualified overpayment will be refunded in a timely manner. We will be happy to arrange payment plans for anyone who is unable to pay their balance; however, most payment plans require a credit card or e-check on file in our processing company's database.

If you should have any questions, please do not hesitate to call our billing office at 602-840-3120, option 6, option 2.

AUTHORIZATION (if you select this option)

I authorize Camelback Pediatrics to charge all balances applied to copay, deductible, coinsurance, or denied for nonpayment of insurance premiums, or any other reason, to the following credit card:

Last 4 digits of credit card:_____ _____ _____ _____ Expiration Date:_____

☐ If the balance due is more than $50, I would like to receive a courtesy call prior to my card being charged.

Contact Number:_____

☐ Please charge my card for the full amount due on any claim.

I understand that once my health insurance(s) process my child's claims, I will receive an Explanation of Benefits (EOB) from my health plan. The EOB will show any balances due that are patient responsibility. I agree that Camelback Pediatrics may charge my credit card on file for the balance due when they receive the EOB from my health plan. I further understand that if payment is denied by the credit card on file, I will not be able to schedule any further appointments until the balance has been paid in full.

_____ _____

Cardholder's Signature Printed Name of Cardholder

CAMELBACK PEDIATRICS, P.C.

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CONSENT BY PROXY FOR NON-URGENT PEDIATRIC CARE*

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. Please review the following authorization for treatment and complete if you wish to authorize such treatment for your minor child(ren) in advance.

***All proxy representatives must be at least 18 years of age and present a valid photo ID at the time of check-in.**

Child's name:_____ DOB:_____

Child's name:_____ DOB:_____

Child's name:_____ DOB:_____

Child's name:_____ DOB:_____

Child's name:_____ DOB:_____

I, _____, have the legal right to delegate such consent to the proxy decision maker, who is an adult* and legally and medically competent to exercise the authority so delegated. I am aware that protected patient health information may be shared with the proxy to facilitate informed decision making.

Proxy Name:_____ DOB:_____ Relationship to patient:_____

Proxy Name:_____ DOB:_____ Relationship to patient:_____

Proxy Name:_____ DOB:_____ Relationship to patient:_____

Proxy Name:_____ DOB:_____ Relationship to patient:_____

LIMITATIONS:

Identify any limitations on the kind of medical services for which this proxy is given. If none, state "none."

_____

_____

Identify any limitations on the time frame for which this proxy is given. If none, state "none."

_____

_____

IN WITNESS WHEREOF, the undersigned have executed this instrument:

_____ _____

Printed Name of Parent/Legal Guardian | Parent/Legal Guardian Signature

_____ _____

Date | Witnessed and I.D. verified by