Mesa Pediatrics
Professional Association

Chandler Office
60 S. Kyrene Rd., Ste. 1
Chandler, AZ 85226
480-785-8700 Fax 480-785-8787

San Tan Office
3592 S. Atherton Blvd., Ste. 101
Gilbert, AZ 85297
480-214-2170 Fax 480-214-2171

Gilbert Office
2550 E. Guadalupe Rd., Ste. 115
Gilbert, AZ 85234
480-632-1544 Fax 480-632-1533

Tempe Office
6301 S. McClintock Dr., Ste. 101
Tempe, AZ 85283
480-831-6800 Fax 480-897-2799

Patient Name: _____

Patient D.O.B.: _____

CONSENT for TREATMENT of a MINOR

I, the parent or Guardian of said patient, who is a minor, authorize Mesa Pediatrics Professional Association (MPPA) and all persons acting as agents thereof and all physicians to.whom said minor is referred for medical treatment, to furnish all forms of diagnostic, preventative and medical treatment to said minor.

This consent shall remain in effect until a written revocation hereof is delivered to MPPA.

AUTHORIZATION and RELEASE

I authorize Mesa Pediatrics to release any information including the diagnosis and the records on any treatment or examination rendered to my child during this period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to Mesa Pediatrics insurance benefits otherwise payable to me.

PAYMENT POLICY

I understand that failure to show up for a scheduled appointment will result in a $25 no-show fee. The first no-show incident may be waived and a reminder letter sent, thereafter a $25 fee will be charged for each no-show incident.

I understand that arriving more than 15 minutes late for a scheduled preventative appointment may result in the need to reschedule the appointment depending on appointment availability.

I understand that if Mesa Pediatrics is not contracted with my insurance carrier I must pay in full at the time of service.

I understand that my insurance carrier may pay less than the actual bill for services. I also understand that some services provided by Mesa Pediatrics may not be covered by my benefit plan. I agree to be responsible for payment of all services rendered.

I understand that all co-payments are due at the time of service. I understand that any balance generated is due within 10 days of the billing date. I realize that failure to keep this account current may result in MPPA being unable to provide additional services.

In the case of default on payment of this account, I agree to pay collections costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding balances.

SEPARATED/DIVORCED FAMILIES

For those families where parents are separated or divorced, the parent who brings the child in to be seen and authorizes treatment is responsible to us for payment. All payments are due when services are rendered. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the responsibility of the authorizing parent to collect payment from the other parent. Mesa Pediatrics will not act as mediator in collecting our payments. If the account is not resolved in a timely manner, the authorizing parent's information will be submitted to our collection agency.

I have received a copy of the Mesa Pediatrics Notice of Privacy Practices dated 4/2003.

I have read and understood the sections titled: *Consent for Treatment of a Minor, Authorization and Release, Payment Policy and Separated/Divorced Families.* I am the parent of said minor child, or the court appointed guardian for the patient and am authorized to act on the patient's behalf to sign this Release of Information.

_____ _____

Signature of Parent or Guardian of Patient Date