TREATMENT CONSENT AND DISCLOSURE

I hereby voluntarily agree to diagnostic procedure(s) and medical treatment(s) which may be administered to or performed on the patient listed below, under the general or specific instructions of the attending practitioner's care and service, or the practitioner's designee(s). I further understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks. No guarantees have been made to me as to the result of the treatment at this office. I understand that my attending practitioner encourages me to ask questions and voice concerns about medical care or services and that asking questions and voicing concerns will not compromise my care.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible and agree to pay any and all charges that are not paid by insurance or any third party payer. I authorize payment directly to Rocky Mountain Pediatric Endocrinology for all benefits otherwise payable to me. I understand that if I do not provide all of the requested/necessary information, I will be billed directly for all charges until such information is provided. I also authorize the release of any medical information necessary to process all claims. Failure to comply with this financial policy may result in the following actions: temporary and/or permanent suspension from the practice and referral to a collection agency.

HIPAA CONSENT

A copy of our patient privacy policy is on display at the front desk, as well as on our website. I may request a copy of this policy at any time. I also understand that if I have any questions about HIPAA or my child's privacy, I may contact Rocky Mountain Pediatric Endocrinology to discuss my concerns. I have reviewed, viewed, or been offered a copy of these policies as required by HIPAA.

Patient Name: _____
Patient DOB: _____

Parent Signature:_____
Date: _____

7336 S. Yosemite St #200 Centennial, CO 80112
Phone: 720-420-ENDO (3636)
FAX: 720-420-3637