



Primary Care Pediatrics and Family Medicine

Consent to Treat

Patient's Name: _____ Date of Birth ___/___/___
Last Name Middle Name First Name

Please sign one of the options below:

Option 1:

I authorize Dr. Shrestha or any Primary Care Pediatrics and Family Medicine, P.C. provider to provide medical care for my child. In the event that my child is brought to the clinic by anyone other than a legal guardian or me, I authorize that my child may be treated in my absence. I understand that I am responsible for settling any costs arising from this care provided in my absence.

The following person(s) have my permission to authorize medical care for my child and sign any necessary waivers on my behalf.

Name	Relationship

For patients 16 years and older ONLY:

The patient listed above may present and be treated unaccompanied by an adult. Yes/No

Signature: _____ Date ___/___/___

Relationship: _____

OPTION 2:

I authorize Dr. Shrestha or any Primary Care Pediatrics and Family Medicine, P.C. provider to provide medical care for my child. In the event that my child is brought to the clinic by anyone other than a legal guardian or me, I do not authorize that my child be treated in my absence. I understand that by signing below, my child will not be treated unless a parent or legal guardian is present.

Signature: _____ Date ___/___/___

Relationship: _____

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____, have received a copy of Primary Care Pediatrics and Family Medicine, P.C, (please print patient name) Notice of Privacy Practices.

Signature of Patient or Legal Guardian

Date Signed



Primary Care Pediatrics
and Family Medicine

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policies, but acknowledgement could be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (specify) _____