EAGAN VALLEY PEDIATRICS PA
18 yr. old General Consent

Patient Name: _____Date of Birth:_____Date:_____

Consent to Treat
I consent to and authorize the physicians, nurses and other healthcare providers at Eagan Valley Pediatrics, PA to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

Assignment of Benefits/Payment for Services
I authorize payment of any and all benefits to Eagan Valley Pediatrics, PA. I understand I must cooperate with Eagan Valley Pediatrics, PA in all efforts to receive payment for services they have provided. If I am eligible for payment from more than one type of coverage, Eagan Valley Pediatrics, PA will return any extra payments to the payor. If I have an unpaid bill at Eagan Valley Pediatrics, PA, any refunds due to me will be applied to my account. If your legal parent or guardian is financially responsible for your care at Eagan Valley Pediatrics P.A., they must be listed as the guarantor. You must provide both parents dates of birth, current addresses and telephone numbers.

Lab Results
I give permission to Eagan Valley Pediatrics to leave a message for _____ (patient name) at the following number

_____re: lab or test results.

Patient Rights and Privacy Practices
You and your family's rights and our privacy practices are posted in main areas within Eagan Valley Pediatrics, PA. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider or Eagan Valley Pediatrics, PA's Privacy Officer.

Reference Laboratory Services
I understand that Eagan Valley Pediatrics, PA utilizes the services of Health East Laboratory to perform some of the lab tests requested by our physicians. I further understand that Health East Laboratory will bill separately for its services. I consent to Eagan Valley Pediatrics, PA providing demographic information as necessary for billing purposes.

My signature here means I have read this information and understand it. This consent is valid until revoked in writing.

Signature: _____Print Name:_____

Email:_____

Name of Interpreter (if used):_____Telephone consent obtained by (Name/Date/Title):_____