Consent to Treat

Patient Name: ____

DOB: _____________________________________

Consent from Parent or Legal Guardian for Authorized Persons

As the legal parent or guardian, I authorize the individual(s) listed below to accompany my child for medical care related to the visit(s) they attend on my behalf.

I understand that the authorized person(s) may provide consent for and receive information related **only to the care provided during that visit**, including:

- Evaluation and treatment
- Vaccinations administered at the visit
- Referrals generated from the visit
- Access to **medical records and health information relevant to that visit**
- Review of medical history **necessary to support care for that visit**

This authorization does **not** grant access to my child's complete medical record beyond what is required for the visit.

Please list the individual(s) authorized to accompany your child for care and provide consent **for visit-related treatment only**.

Full Name of Authorized Person	Relationship to Child
______________________________	_______________________
______________________________	________________________
_______________________________	________________________

If no one else is authorized to accompany or consent for your child, please check below:

☐ None / No Authorized Persons

Parent/Legal Guardian Name ________________________________

Parent/Guardian Signature Date

(Valid for 1 calendar year, must be updated every year)

Desert Valley Pediatrics – Office Policies

Financial Policies

Insurance & Payment
DVP will submit claims to your insurance as a courtesy. **Payment is due at the time of service** for co-pays, deductibles, co-insurance, and non-covered services. Co-pays **cannot be waived**. Payment is collected during **pre-visit or in-office check-in**.

Patients are responsible for understanding their benefits and **assigning DVP as their PCP** when required. For out-of-network benefits, claims will be submitted as a courtesy; any remaining balance is the guarantor's responsibility. Notify DVP of changes to insurance, address, or phone number.

Medicaid
Patients must have **active coverage**. If not, the visit may be considered **self-pay**. Non-covered services are the guarantor's responsibility.

Self-Pay Patients
Patients without insurance are considered self-pay. **Full payment is due at the time of service**. Our current list of fee can be found on our website www.dvpeds.com or you may contact the office information.

Returned Checks
There is a **$35 fee** for returned checks. Payment must then be made in **certified funds**. Personal checks will no longer be accepted on the account.

Past Due Accounts
Past due balances may result in billing statements, notices, and collection calls. Accounts with unpaid balances may have **restricted scheduling** until resolved.

Laboratory Fees: You will receive a separate laboratory fee for outside lab services. Any lab services that are not covered by your insurance will be your responsibility. It is your responsibility to go to a contracted lab. Desert Valley Pediatrics is not affiliated with any labs.

Elective Procedures
Circumcisions and ear piercings may not be covered by insurance. **Full payment is required at the time of service**. Checks are **not accepted**.

Appointments & Scheduling

Appointments
Walk-ins and sibling add-ons are **not accepted**. Urgent concerns should be addressed through a **triage nurse**. Text or call if you are late for your visit time. Staff will determine whether you can be accommodated or must **reschedule**.

No Shows & Late Cancellations
Appointments cancelled **<6 hours** before the visit or missed appointments may affect other patients. Three (3) occurrences within **6 months** may result in **dismissal** from the practice.

Visit & Billing Information

Visits and Coding
Providers code based on **all care provided**. Significant problems addressed during Well Child Checks may result in **additional billing**. Both preventive and problem-oriented services may be billed if provided.

Communication & Family Responsibilities

Visit Information
Providers will **not** conduct post-visit phone reviews. Summaries and instructions are available via the **patient portal**. Families are encouraged to have **both parents/guardians** present when possible.

Divorce & Custody
DVP cannot intervene in parental disputes. The parent or guardian bringing the child is **financially responsible**. Parents must communicate scheduling and cancellations with each other. Repeated disruptions may result in **scheduling restrictions or other consequences**.

Privacy & Consent

DVP is committed to protecting your child's privacy. Our **Notice of Privacy Practices** explains use and disclosure of protected health information. You may review it anytime; updated copies are available.

By signing, you consent to DVP's use and disclosure of health information for **treatment, payment, healthcare operations and receipt of the Health Current's Notice of Health Information Practice**. Treatment may be conditioned on this consent. Requests for disclosure restrictions must be in writing; any agreed restrictions will be honored.

This consent remains in effect until revoked in writing.

Patient Name: ____________________________________**Patient DOB:** ____________________

Responsible Party Name (Please Print): ____

Your signature: ____ **Date:** ____________________