Diana McLaughlin, M.D., F.A.A.P.
Kids' Medical Care
2336 Immokalee Road, Naples FL 34110
Phone: (239) 591-8481
Fax: (239) 596-0212
www.kidsmedicalcare.com

PATIENT INFORMED CONSENT

Consent for Treatment:

I hereby agree and consent to authorize Diana McLaughlin, M.D., P.A., D/B/A Kids' Medical Care, physicians and staff to provide medical evaluation, treatments and services which may include but not limited to lab work, immunizations, medications and health screenings. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of the named individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Consent for Payment and Assignment of Benefits:

PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED. We accept payment in cash, checks, VISA and MasterCard. However, Kids' Medical Care agrees to accept assignment of benefits for patients in participating insurance networks.

- I hereby authorize and direct payment to Diana McLaughlin, M.D., PA, D/B/A Kids' Medical Care for the surgical and/or medical benefits, if any, otherwise payable to me under terms of insurance.
- I understand that I am responsible for any amount not covered by insurance including but not limited to Co-pays, Co-Insurance, Deductibles, and/or non-covered services.
- I hereby authorize Kids' Medical Care to furnish and/or release any information to insurance carriers concerning illnesses and treatments, acquired in the course of my examination and/or treatment, in order to process my insurance claim. This order will remain in effect until revoked by me in writing.
- I understand that Kids' Medical Care has the right to pursue legal action against myself, guarantor and/or the insurance in the recovery of all payments owed including but not limited to fees, charges administrative fees, pre-judgment interest, post-judgment interest, court costs and attorney's fees.
- I hereby authorize photocopies of this form to be as valid as the original.
- I understand that there will be a charge for copying of medical records pursuant to F.A.C. 64B8-10.003.

Notice of Privacy Practice Receipt:

I acknowledge that I was provided the Notice of Privacy Practices for Kids' Medical Care**.**

I, declare that I have read and fully understand the above stated agreement. This agreement will survive beyond the termination of the physician/patient relation with Kids' Medical Care.

Patient's Name _____ _____ **Date of Birth:** _____
Print Parent's or
Legal Guardian's Name: _____ **Date:** _____

Signature: _____ _____ **Relationship:** _____

Witness Name: _____ **Medical Record#:** _____