# **Blooming Pediatric & Family Nurse Practitioners, P.L.L.C.**

Michal Hovak FNP & Coral Montana PNP Phone : 315-662-0162

1 Oxford Crossing, Suite 3 Fax: 315-662-0107

New Hartford, NY 13413 Email : Admin@BloomingPeds.com

# **Consent For Treatment Of A Minor**

I, The parent or guardian of patient stated below, who i.e. a minor, authorize Blooming Pediatric & Family Nurse Practitioners and all persons acting as agents thereof and all nurse practitioners to whom said minor is referred for medical treatment, to furnish all forms of diagnostics, preventative and medical treatment to said minor. This consent shall remain in effect until a written revocation hereof is delivered to Blooming Pediatric & Family Nurse Practitioners PLLC. **Initials (Parent or Guardian): \_\_\_\_\_**

# **Policies, Procedures & Privacy Rights Agreement**

**Child(ren)’s name(s) & Date of Birth**

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# **Insurance information**

**Insurance Type**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ID #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Group #** (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured person’s name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured person’s relationship** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insured person’s date of birth** \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_\_\_

**Phone number** \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

**Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient/Parent/Legal Guardian signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Staff witness signature**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**  \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

**Notice of Privacy Practices**

Acknowledgement of receipt:

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient/parent/legal guardian)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment of Benefits**

Acknowledgement of receipt:

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient/parent/legal guardian)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Agreement**

Acknowledgement of receipt:

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient/parent/legal guardian)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_