400 Athletic Club Blvd Unit 101
Clayton, NC 27527
Phone : (919) 267-1499
Fax : (919) 250-6272

23 Sunnybrook Rd. Suite 116
Raleigh, NC 27610
Phone : (919) 250-3478
Fax : (919) 250-6272

Consent to Treat

1. I _____ **(*parent/guardian name*)** give permission for **KIDS FIRST PEDIATRICS** to give _____ **(*patient name*)** medical treatment.
2. I allow **KIDS FIRST PEDIATRICS** to file for insurance benefits to pay for the care the patient receives.

   I understand that:
   - **KIDS FIRST PEDIATRICS** will have to send the patient's medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with a clinician.

Patient Name _____

Parent/Guardian Name_____ **Relationship**_____

Parent/Guardian Signature _____ **Date**_____

Consent to Treat Form.
Content last reviewed September 2020.
Agency for Healthcare Research and Quality, Rockville, MD.
https://www.ahrq.gov/health-literacy/improve/precautions/tool11d.html