KidsWatch Pediatrics and Urgent Care - Consent to Treat Form

Patient Information:

- Patient Name: _____
- Date of Birth: _____
- Parent/Legal Guardian Name (if applicable): _____
- Relationship to Patient: _____

Consent to Treatment:

I, the undersigned parent/legal guardian of the above-named patient (or the patient, if 18 years of age or older), hereby consent to medical treatment by physicians, nurses, and other healthcare professionals at KidsWatch Pediatrics and Urgent Care. This consent includes, but is not limited to:

- Examinations
- Diagnostic tests (e.g., X-rays, blood tests)
- Medical procedures (e.g., vaccinations, wound care)
- Administration of medications
- Other medically necessary care as determined by the healthcare provider

I understand that I have the right to ask questions about my child's/my medical care and to refuse any specific treatment. I agree to discuss any concerns I have with the healthcare provider.

Consent to Urgent Care Treatment:

I understand that KidsWatch Pediatrics and Urgent Care provides urgent care services. I consent to treatment for urgent medical needs, which may include conditions requiring immediate attention to avoid serious harm. I understand that in some cases, further evaluation or treatment at a hospital may be necessary.

Consent to Release Information (HIPAA Compliant - *Needs Legal Review*):

I authorize KidsWatch Pediatrics and Urgent Care to release protected health information (PHI) about my child/myself to:

- My insurance company(ies) for billing purposes.
- Other healthcare providers involved in my child's/my care, for coordination of care.
- Others as permitted or required by law (e.g., reporting of suspected abuse or neglect).

KidsWatch Pediatrics & Urgent Care
(P) 703-775-0777 (F) 703-589-9699
www.kidswatchpedaitrics.com
7263-F Arlington Blvd, Falls Church, VA 22042

I understand that I have the right to receive a Notice of Privacy Practices, which explains how my child's/my PHI may be used and disclosed.

Financial Responsibility:

I understand that I am financially responsible for all medical services provided to my child/myself at KidsWatch Pediatrics and Urgent Care. I agree to pay all charges according to the center's policies. I understand that my insurance coverage may not cover all services and that I may be responsible for co-pays, deductibles, and other out-of-pocket expenses.

Acknowledgement:

I have read and understand this Consent to Treat form. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

Signature of Parent/Legal Guardian (or Patient if 18 or older)

Printed Name

Date

Witness Signature (if required by state law)

Witness Printed Name

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