Carolina Pediatric Associates
Professional, Personalized Care for newborns,
Children, & Adolescents

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Gaffney Location
1610 N.Limestone St.
Gaffney, SC 29340
Blacksburg Location
301 W. Pine St.
Blacksburg, SC 29702

AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT, PAYMENT GUARANTEE, AND NOTICE OF PRIVACY PRACTICES

- **CONSENT FOR MEDICAL TREATMENT:** I understand that the office has an obligation to provide screening and emergency medical treatment when appropriate and to provide appropriate care and treatment of all patients. I hereby authorize the physician(s) and/ or midlevel practitioner in charge of my child's case to administer treatments as deemed necessary or advisable in the treatment of any condition of my children.
- **PAYMENT GUARANTEE:** I/we agree to pay the established rates of the clinic for all services rendered.
- **RELEASE OF MEDICAL INFORMATION:** I do hereby authorize the office Carolina Pediatric Associates, to release medical or other information about me or my child(ren) to any insurance companies involved or any other agency assisting in the payment for the patient's care.
- **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT:** By signing this form, you acknowledge receipt of the notice of privacy practices of Carolina Pediatric Associates. Our notice of privacy provides information about how we may use and disclose your protected health information. We are required by federal law to obtain your acknowledgement that you have received this notice. If you have any questions about our notice of privacy practices, please contact us at 864-839-4325.
- **USE OF PHONE NUMBER AND EMAIL:** I hereby authorize Carolina Pediatric Associates to send me text messages and/or emails regarding upcoming appointments and health announcements.

THE UNDERSIGNED CERTIFIES HE/SHE HAS READ AND UNDERSTANDS THE ABOVE INFORMATION/AUTHORIZATION. IT ALSO CERTIFIES YOU HAVE RECEIVED OUR NOTICE OF PRIVACY PRACTICES.

Patient Name: _____ **Date of Birth:** _____

Parent/Guardian Signature: _____ **Date:** _____