# GENERAL CONSENTS

I give permission for my child _____ to receive medical service by the physicians at Westchester Pediatrics, LLC. I understand that a complete medical examination may include the external examination of the external genitalia and rectum. In the event that I am not available to bring my child to the office and he/she is brought in by a relative, medical services may be performed.

**RELEASE OF MEDICAL RECORDS**

I authorize payment of medical benefits to the physicians of Westchester Pediatrics, LLC, for any medical services rendered.

**ASSIGNMENT OF BENEFITS**

I authorize payment of medical benefits to the physicians of Westchester Pediatrics, LLC, for any medical services rendered.

**OFFICE BILLING POLICIES**

This office is willing to bill your insurance company for you, once benefits have been verified. You will be responsible for any deductibles, co-insurance, co-payment, or non-covered benefits due.

In the event that benefits or member edibility cannot be verified, you will be responsible for all charges and balances incurred.

If my child is a newborn, I understand that I have to contact my insurance company to enroll the baby (most insurance companies will give you thirty days to enroll your newborn, check with your carrier). If enrollment is not completed within thirty days, I will be responsible for any charges incurred since birth.

If contracted with an HMO I must give them the name of the patient's primary care physician at Westchester Pediatrics, LLC. If Westchester Pediatrics, LLC physician was not chosen, I am aware that I will be responsible for all charges incurred.

I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE MENTIONED INFORMATION.

SIGNATURE _____ DATE _____

PRINT NAME _____