Rocky Mountain Pediatric Respiratory and Allergy Care

Acknowledgement of Financial Responsibility
Rocky Mountain Pediatric Respiratory and Allergy Care will file all claims of applicable visits and procedures. I, ___________________________________, acknowledge that I will be responsible for payment of all deductibles, co-insurance and non-covered services. Please remember that insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for payment rests with you.

Consent to Treat
I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment.
I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.
I understand that **HealthONE Clinic Services** may include consent at satellite offices under common ownership.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____
Patient Name

___________________________________ ___________________________
Patient (or responsible party) Signature Date