SPRING HILL
Pediatric Care

Consent to Treat Form

1. I _____ (parent/guardian's name) give permission for **Spring Hill Pediatric care** to provide medical treatment for:

   Child/children: _____ D.O.B. _____
   _____ D.O.B _____
   _____ D.O.B _____

2. I allow **Spring Hill Pediatric Care** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - **Spring Hill Pediatric Care** will have to send my 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 agree until I mention otherwise in verbal or writing that medical information regarding my child's diagnosis and treatment may be released to biological parents, siblings, referring physicians involved in my child's care.

_____ _____

Patient/Legal Guardians' Signature Date