Authorization of Consent for Medical Treatment

Because my child, _____, must at times be left in the care of unrelated persons, we the parents/legal guardians of _____, grant full and unconditional permission to any physicians associated with Chickahominy Family Practice, Inc. to perform and/or authorize any treatment he or she deems necessary for the care of _____.

This notice authorizes and covers any treatments, procedures and medicines prescribed by stated physicians until such time that a parent or legal guardian can arrive on the scene and be consulted by the physician.

_____ _____

Signature of Parent/Legal Guardian **Date**

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MEDICARE AUTHORIZATION

_____ _____ _____

Patient's Signature **Medicare Number** **Date**

I request that payment of authorized Medicare benefits be made either to me or on behalf to Chickahominy Family Practice, Inc. for any services furnished me by my provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.