Sunshine Pediatrics of St. Augustine
Authorization and Consent to Treatment

Consent to Treatment. I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my child's health and well-being; however, I may refuse any treatment or procedure. My consent shall cover medical examinations and diagnostic testing, including, but not limited to, minor surgical procedures (including suturing), and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of her staff have made any guarantee or promise as to the results that I will obtain.

Assignment of Benefits and Authorization to Release Medical Information. I have read and understand the Office Financial policy for Sunshine Pediatrics of St. Augustine and agree to comply and accept responsibility for any payment that becomes due as outlined previously. I authorize the use of this signature on all insurance submissions and authorize payment directly to Sunshine Pediatrics of St. Augustine/Shelby Cline MD for all insurance benefits otherwise payable to me for services rendered.

HIPAA. By signing this form, I hereby give my consent for Sunshine Pediatrics of St. Augustine to use and disclose protected health information (PHI) about my child to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Sunshine Pediatrics of St. Augustine describes such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Sunshine Pediatrics of St. Augustine reserves the right to revise its Notice of Privacy Practices at any time. I have the right to request that Sunshine Pediatrics of St. Augustine restrict how it uses or discloses my PHI to carry out TPO and may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Consent to Call, Email & Text. With this consent Sunshine Pediatrics of St. Augustine may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO for my child, such as appointment reminders, insurance items and any calls pertaining to clinical care, including laboratory test results, among others. With this consent, Sunshine Pediatrics of St. Augustine may email, text, or mail to my home, cell phone or other alternative location, any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

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Print Patient's Name Date

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Signature of Parent or Legal Guardian