Consent to Treatment and Use of Health Information

Alena Ashenberg MD, Pediatrics
Boston Children's
Primary Care Alliance

ashenbergpedi.com
978-957-4300 | *fax* 978-957-3891

Consent for medical treatment

I allow the healthcare providers of Alena Ashenberg MD, Pediatrics to give the patient named below medical care, including medical examinations, diagnostic testing or procedures, administration of medications, treatment, and other medical services as determined by the provider.

I understand that absent emergency circumstances, major therapeutic and diagnostic procedures will not be performed unless I have had the opportunity to discuss such procedures and the risks associated therewith to my satisfaction and I have consented to such procedure.

I understand that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made to me promising any specific result or outcome.

Release of information for payment and assignment of benefits

I agree that Alena Ashenberg MD, Pediatrics can share the patient's health information with the patient's health plan or other payment source in order to receive payment for services rendered.

I hereby assign to Alena Ashenberg MD, Pediatrics the right to health insurance benefits otherwise payable to me or the patient on account of the care provided, and I authorize such medical insurance benefits to be paid directly to Alena Ashenberg MD, Pediatrics.

I agree to cooperate and provide information as needed to establish my eligibility for such benefits. A copy of this assignment and authorization may be used in place of the original.

This approval will remain in effect until the patient leaves Alena Ashenberg MD, Pediatrics.

Acknowledgment

Patient's name: _____

Patient's date of birth: _____

Parent/Legal guardian's name (if applicable):

_____

Relationship to patient: _____

Signature of parent/legal guardian (or patient if 18 or older):

_____

Date: _____