# Windhaven Adolescent & Sports Medicine

**PATIENT'S NAME:**_____ **PATIENT'S DOB:**_____

**CONSENTS :**

1. ASSIGNMENT OF BENEFITS: I Hereby assign all medical and surgical benefits to the attending Physician. This agreement will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid for by the said insurance company. I hereby authorize said assigned to release all information that may be needed to secure payment.

_X_____
Signature of patient (or guardian if under 18 yrs old) DATE

2. AUTHORIZATION FOR TREATMENT: I hereby authorize Laura H. Scalfano, MD and any such assistant or physician as she designates, to render any necessary or advisable treatment.

__X_____
Signature of patient (or guardian if under 18 yrs old). DATE

3. *Please read first!* AUTHORIZATION FOR PATIENT TO CONSENT TO TREATMENT WITHOUT PARENT PRESENT: I _____ (name of parent or legal guardian) hereby authorize my child/ward, _____ (name of child/patient) to consent to treatment in my absence.

_X_____
Signature of parent or guardian DATE

4. AUTHORIZATION TO CONTACT: I hereby authorize Laura H. Scalfano, MD and any of her representatives or staff to contact me by the methods listed here. Our practice may use or disclose the patients PHI to contact you by phone, voice mail, email, text.
_____email
_____phone (text)
_____phone (voice mail)

_X_____
Signature of patient (or guardian if under 18 yrs old) DATE

5. RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT:
I acknowledge that I have received, or have been offered a copy, of the Windhaven Adolescent and Sports Medicine Notice of Privacy Practices._____(initial)
**OR** I have DECLINED to receive the Notice of Privacy Practices offered by Windhaven Adolescent and Sports Medicine. I understand that I do not have to sign the acknowledgment in order for me/the patient to receive treatment by Windhaven Adolescent and Sports Medicine._____(initial)

_X_____
Signature of patient (or guardian if under 18 yrs old) DATE

6. AUTHORIZATION OF THE RELEASE OF VACCINE RECORDS OR SCHOOL/WORK EXCUSES BY VERBAL REQUEST: I hereby authorize Laura H. Scalfano, MD or her representatives to release my vaccine records or a school/work release on my verbal request to the facility of my choosing.

_X_____
Signature of patient (or guardian if under 18 yrs old). DATE