Authorization to Give Consent for Medical Treatment

Child/Patient Name: _____

Date of Birth: _____ Patient ID: _____

Until revoked in writing, the following persons are authorized to act on my behalf:

1. To give consent for medical treatment of my child named above including, but not limited to, testing my child's blood for HIV antibodies in accordance with the laws of Virginia, which authorize health care workers to test patients when a health care worker is exposed to body fluids of a patient;
2. To assign benefits of third-party payors for direct payment to Ear, Nose and Throat, LTD; and
3. To receive financial information regarding my child's health care and/or medical information about my child's condition, treatment or health care received at Ear, Nose and Throat, LTD.

I agree that the following persons, 18 years of age or older, are authorized to sign on my behalf the following statement, thus binding me to its terms in my absence; the undersigned patient and/or responsible party(ies) agree that in consideration of services rendered to the patient, each of them jointly and severally, will pay and guarantee payment of the physicians bill in accordance with the regular terms and charges of the physician. Any portion of the bill not covered by insurance will be due within 30 days of receipt of the invoice unless other arrangements are made with Ear, Nose and Throat, LTD's billing staff.

It is further agreed that in the event of a non-payment, that the physician shall have the right to proceed against me or the responsible party(ies) without making any demands of or taking any action or proceeding against each other as a prerequisite. The undersigned agree(s) to pay all costs of collection including collection agency fees and attorney fees in the amount of thirty-three and one third percent (33.3%) of the amount owed.

Authorized persons:

First Name	MI	Last Name	Relationship to Child	Date
First Name	MI	Last Name	Relationship to Child	Date
First Name	MI	Last Name	Relationship to Child	Date

Parent/Legal Guardian Name (Printed)

Parent/Legal Guardian Signature Date