Express Care Clinic/West Lincoln Family Medicine
201 Capitol Beach Boulevard, Suite 1A
Lincoln, NE 68528
402-435-0228

CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD

I, _____, certify that I am the parent/legal guardian of _____, a minor ("Child"), and that I am authorized to provide informed consent for any medical treatment provided to my Child. I hereby give my express consent for the health care providers at Pine Lake Health, LLC ("Clinic") to perform the following procedures on my Child:

_____ Diagnostic procedures such as laboratory tests (e.g., urinalysis, blood work, cultures), X-rays and physical examination;

_____ Medical treatment as deemed necessary by the Clinic healthcare providers;

_____ Immunizations; and

_____ Ongoing treatments or therapy (e.g., allergy shots)

I understand the nature of the treatment or procedures, and I acknowledge that no guarantees have been made to me or my Child as to the results of treatment or examination performed at the Clinic.

Futhermore, I acknowledge that I am financially responsible for any and all medical examinations and treatments provided to my Child at the Clinic. I hereby assign and authorize payment directly to the Clinic any and all third party payor benefits otherwise payable to me. I hereby agree that the Clinic may issue a receipt for any such payment and that this receipt shall be a conclusive acknowledgment by me that I have received insurance benefits from the insurance company(ies) in the sum specified in such receipt, and agree that such payment shall discharge the insurance company(ies) of any and all obligations under the policy(ies) to the extent of such payment and for that purpose. I expressly authorize the Clinic to furnish the insurance company(ies) with any information desired concerning said medical care and treatment. I understand that I am financially responsible to the Clinic for charges not covered by this assignment and further agree to guarantee prompt payment in full of any balance due.

I further authorize _____ to be present during medical treatment of my child.

A photocopy of this document shall be considered as valid as the original.

Dated this ____ day of _____, _____.

_____ _____witness

Signature of Parent or Legal Guardian