CHILDREN OF JOY PEDIATRICS, P.C.

134 Summit Avenue
Hackensack, NJ 07601
(201)525-0077 Fax#: (201)525-0072

GENERAL CONSENT FORM

Date:_____

SECTION A: PATIENT INFORMATION

Patient Name:_____ Date of Birth_____ Soc Sec#:_____

SECTION B: GENERAL CONSENT TO TREATMENT

I do hereby authorize Dr. Rosa Josephina Miranda and the assistant/s that she may designate to perform the treatment/procedure(s) that are reasonable, necessary, and advisable. I have been informed of the reasons for the treatment/procedure(s), along with the expected benefits, risk, and possible consequences involved.

Understanding this, I authorize Dr. Rosa Josephina Miranda to perform such examinations, treatment, laboratory tests, and to administer such medications as, in his or her opinion, are necessary or advisable for my son/daughter whose name appears above. I understand I may withdraw my consent, at any time, to the extent permitted by law.

SECTION C: INSURANCE AUTHORIZATION

I hereby authorize direct payment of medical benefits to Dr. Rosa Josephina Miranda for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Medicaid: I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

SECTION D: CONSENT FOR USE AND DISCLOSURE

I have been offered a copy of and have full opportunity to read and consider your Notice of Privacy Practices. This Notice provides a description of our treatment, payment activities and healthcare operation, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information as described on the Notice of Privacy to carry out treatment, payment activities and healthcare operations.

SIGNATURE:

Signature of Parent, Guardian or personal Representative:_____

Printed Name of Parent, Guardian or Personal Representative:_____

Relationship to Patient:_____ Witness:_____