

**Consent for Treatment**

I do hereby consent to necessary examination procedures and/or treatments prescribed by my physician (Dr. Danielle Grant) as is necessary in her judgment.

**Financial Responsibility and ACH Authorization**

I understand payment is due in full at the time of service unless special payment plan arrangements have been made with our Business Services. If my insurance is a PPO/HMO with which Beansprout Pediatrics contracts with, I am responsible for my co-payments, deductibles, and non-covered services. I understand that if my insurance carrier is one with which Beansprout Pediatrics has a contract, that contract includes a provision for benefits to be paid directly to the group.

**Assignment of Benefits**

I understand that if my insurance is not contracted with Beansprout Pediatrics, but I have made prior arrangements with Business Services, that in special situations, Beansprout Pediatrics may file my insurance claims assigned. In such case, I authorize payment of benefits to be made to Beansprout Pediatrics, PLLC.

**Authorization of ACH Debit for NSF Checks**

I authorize ACH debits if my check is returned unpaid by my bank for any reason. I authorize Beansprout Pediatrics to initiate, directly or by agent, an ACH debit of my account, in the amount of the check, plus any bank fees incurred by Beansprout Pediatrics, plus a collection fee in the amount between \$8.00 and \$40.00 as permitted by law. I understand that this authorization may be revoked at any time by providing written notice to Beansprout Pediatrics.

**No-Show Policy**

Out of courtesy to other patients, there will be a \$25.00 fee for all consultations cancelled or rescheduled with less than 24 hour notice. For those patients scheduled for a nuclear test, there is a time sensitive chemical that will be wasted if you do not give at least 24 hours notice of your cancellation or rescheduling. Without enough advance notice, you will be charged \$142.00 for the chemical dose. This amount will not be covered by your insurance.

**Form Completion and Copy of Medical Records**

To cover the cost of Physician and Staff time to complete these request there may be an applicable fee. For more information please see a BSP representative.

\_\_\_\_\_  
Signed (Insured Person)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness