** Parent Delegation Form**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle

D.O.B.: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_

**Delegation of Care**

I, the undersigned parent/guardian of the patient listed above, authorize Kids Klinic, LLC to deliver any necessary treatment or immunization(s) to my child when brought by myself or another responsible party or when alone (if ≥ 14 years old) during this and all subsequent visits. The necessary treatments may include, but are not limited to: medicines, immunizations, imaging, performance of procedures or other studies.

I, the undersigned parent/guardian of the patient listed above, authorize the following persons to present my child to Kids Klinic, LLC. for medical care in my absence and authorize them to sign for immunizations or any other treatments that are deemed necessary by Kids Klinic, LLC and its personnel. The following persons are the ONLY people (other than the patient’s biological parents or legal guardians) authorized to bring your child to the doctor’s office. This delegation shall be valid until I withdraw my delegation of consent.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Delegation of Records/Demographic Information**

I permit Kids Klinic, LLC. to furnish any medical or demographic information requested by insurance companies with whom I have coverage or public agency which may be assisting in payment of the patient’s care and/or any provider(s) referred to or any provider(s) referring this patient for treatment. I am aware that if I need limitations or restrictions on the patient’s records, I am to inform Kids Klinic, LLC immediately along with the necessary documentation.

I consent that Kids Klinic, LLC., and/or any affiliates or vendor, may call my home or other designated location and provided telephone numbers, and may leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations.

**Delegation of Payment**

I hereby authorize payment directly to Kids Klinic, LLC of benefits otherwise payable to me including major medical insurance and payment of medical benefits, but not to exceed the Kids Klinic, LLC. charges for these services. I understand that I am financially responsible to Kids Klinic, LLC for charges not covered by this assignment, including all co-pays, deductibles, co-insurance and/or unpaid balances not covered by insurance regardless of marital status. Therefore, I acknowledge that regardless of insurance coverage, I am responsible for my account, and my account to be paid within 30 days. I understand that if this account is referred to an attorney, I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection and enforcement, including attorney fees. I also authorize that refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

**By signing this form below, I certify that I am the authorized parent or authorized agent/guardian of the patient and knowledgeable to furnish the information requested above.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print Name of Parent/Legal Guardian Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

 Signature of Parent/Legal Guardian Today’s Date