Pediatric Mobile Care

Consent to Treat/Notice of Privacy Practices 2025

Patient Name: _____ Date of Birth: _____

Consent to Treat

I consent to and authorize the physicians, nurses, and other healthcare providers at Pediatric Mobile Care (PMC) to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration for me or my child as deemed medically necessary in their professional judgment. I know that there are some risks with all medical treatments and procedures, and I understand that no one can guarantee how well treatments or procedures will work. I understand that I have the right to be informed of the nature and purpose of all services provided to me or my child at PMC, as well as alternatives, risks, consequences, or complications of such services.

Notice of Privacy Practices

My signature below indicates that I understand I have access to a copy of the Notice of Privacy Practices for Pediatric Mobile Care (PMC) at any time by requesting a physical copy or viewing the Notice of Privacy Practices for PMC on the clinic's website www.pedsmobilecare.com.

X

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PATIENT SIGNATURE OR SIGNATURE OF GUARDIAN OR PARENT **DATE**