

Pediatric Neurology of Lehigh Valley
Boosara Ratanawongsa, M.D
961 Marcon Blvd. Suite #452
Allentown, PA 18109
(P) 610.398.9898
(F) 610.398.9899



CONSENT FOR TREATMENT

In presenting my child for diagnosis and treatment, I hereby voluntarily authorize Pediatric Neurology of Lehigh Valley, through its appropriate personnel, to perform or have performed upon me or my child, appropriate assessment and treatment procedures as may in the providers professional judgement be necessary. I further authorize Pediatric Neurology of Lehigh Valley, to release to appropriate agencies, any information acquired in the course of my child's examination and treatment.

I give my consent to the provider and staff of Pediatric Neurology of Lehigh Valley to perform medical services determined to be necessary or advisable for the benefit of my child's healthcare including visits that may be more than the typical office visit time. Pediatric Neurology of Lehigh Valley is authorized to use and disclose my protected health information for treatment, payment, and operations consistent with its Notice of Privacy Practices.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I have read this form and certify that I understand its contents.

By signing below, I certify that I have read, reviewed carefully, and fully understand and accept the terms of treatment for me or my child provided by Pediatric Neurology of Lehigh Valley. Furthermore, you understand it is your responsibility to stay compliant with all of our treatment practices.

PATIENT NAME

DOB

GUARANTOR NAME (PRINTED)

DOB

PARENT/GUARANTOR SIGNATURE

DATE