Willow Tree
PEDIATRICS

P: 256.735.4632 F: 256.735.4639
1167 COUNTY RD 437, SUITE B
CULLMAN, AL 35055

Consent to Treatment

I hereby give my permission for Willow Tree Pediatrics to give

_____ medical treatment.

I give permission for Willow Tree Pediatrics to file for insurance benefits to pay for the care

_____ receives.

I understand that:

- Willow Tree Pediatrics will send medical record information to my insurance company.
- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.
- It is my responsibility to keep Willow Tree Pediatrics updated with my correct insurance information.
- Upon arrival I will verify that Willow Tree Pediatrics has the most updated insurance information on file.
- If the insurance information I present is incorrect, I will be responsible for payment of the visit.
- If my insurance has not been informed that Willow Tree Pediatrics is my primary care provider, I may be financially responsible for my visit charges.
- It is my responsibility to understand my insurance plan benefits.
- Not all plans cover well child visits, vision/ hearing screenings, developmental screenings, or physicals. If these services are not covered, I will be responsible for payment.
- If my insurance plan allows a certain number of visits per year and those visits have been exceeded, I will be responsible for payment.

Parent/ Guardian Signature: _____ Date: _____