GENERAL CONSENT TO TREATMENT

Patient's Name: _____

Date of Birth: _____

I _____, am the parent or legal guardian duly authorized to give consent on behalf of the patient listed above. I understand that by signing below, I am providing a general consent for the patient listed above to receive health care services from Valley Children's Primary Care Group. I understand that I may revoke this general consent at any time. The consent will remain in full effect until it is revoked.

I further acknowledge that Valley Children's Primary Care Group may request that I review and execute additional informed consent documents prior to the above-named patient receiving certain treatment or undergoing certain procedures. Prior to signing an additional informed consent document, Valley Children's Primary Care Group will provide me with all information that is pertinent to deciding whether to consent to the recommended procedure or treatment for the above named patient. Such information will include, but not be limited to: 1) the nature of the recommended treatment; 2) the risks, complications, and expected benefits of the recommended treatment including, but not limited to, the likelihood of success; and 3) any alternatives to the recommended treatment, and the risks and benefits to the alternative treatments.

I have read the above and hereby generally consent to the above named patient receiving health care services from Valley Children's Primary Care Group.

_____

Parent/Guardian Signature Date

_____

Print Name Date