

Grove Pediatrics & Adolescent Medicine

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Consent for Treatment & Office Policy Acknowledgment

Patients Covered by This Consent

List up to three (3) children covered by this consent and policy acknowledgment.

Patient 1 — Full Name:

Date of Birth:

Patient 2 — Full Name:

Date of Birth:

Patient 3 — Full Name:

Date of Birth:

Consent for Treatment

I, the undersigned parent/legal guardian, give my voluntary consent for Grove Pediatrics and its physicians and staff to examine, treat, and administer routine care — including diagnostic procedures, immunizations, and medically necessary treatment — to my child(ren) named above. I understand I will be informed of any significant findings and consulted regarding treatment decisions whenever possible.

Vaccine Policy

Grove Pediatrics maintains a strict vaccine policy. We believe children should receive vaccines on the schedule recommended by the American Academy of Pediatrics (AAP) and the CDC, unless medically contraindicated. For the safety of all patients in our care, we are unable to accept or continue seeing families who refuse or wish to delay recommended vaccines.

Financial Policy

I understand and agree to the following office policies:

Policy	Details
Appointments	Please arrive on time with ID and your child's insurance card.
Walk-ins	We see patients by appointment only. If we are able to fit you in without an appointment, a \$30 walk-in fee applies (not covered by insurance).
Rescheduling	Requires 24 hours' notice. Within 24 hours: \$30 fee.

Policy	Details
No-shows	\$50 (well visit) / \$30 (sick visit). Due before next appointment is scheduled.
Payment	Self-pay and non-participating insurance patients pay at time of service.
Forms & Paperwork	Free if brought to or requested during a well visit. Forms can only be completed if your child has had a physical exam in our office within the past 12 months. \$15 fee per form for completing school, camp, daycare, sports, or other paperwork outside of a scheduled visit. Please allow 3-5 business days. Rush service: \$30 per form for next-business-day completion.

Acknowledgment

[] I have read and agree to the above Consent for Treatment, Vaccine Policy, and Financial Policy.

Signature (Parent/Guardian):

Date:

Printed Name:

Relationship to Patient(s):
