Newport Children's
@ Mission
Medical Group

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26800 Crown Valley Pkwy • Suite 460 • Mission Viejo, CA 92691

# INFORMED CONSENT

I hereby authorize the administration of: _____

For my child: _____ .

I have been informed my insurance carrier **WILL NOT** be billed for the above service and I am responsible for payment. I understand my insurance carrier either does not cover the above service or does not reimburse the medical group to cover the expense of the service.

If I choose to bill my carrier on my own and the insurance makes payment to Newport Children's Medical Group @ Mission, I will be refunded the amount insurance has paid. Newport Children's Medical Group @ Mission does not accept the allowed amount or any contractual allowance that my insurance carrier determines.

_____ _____

PARENT NAME (PLEASE PRINT) DATE

_____

PARENT SIGNATURE