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**Lynzie E. Boudreaux, M.D. Maurice B. Faugot, M.D. Allison Z. Rader, M.D.**

**295 INDEST STREET NEW IBERIA, LA 70563**

**PHONE: (337) 365-0268 or (337) 365-5437 FAX: (337) 369-6922**

**AUTHORIZATION FOR CHARGES AND BENEFITS**

**CONCERNING PHYSICIAN CHARGES:**

I understand that there may be charges for services that may not be fully covered by my insurance. I also understand that services are rendered and charged to me, not my insurance carrier, at the time of service. Therefore, acting as legal guardian of this child, I understand that I am personally responsible for all charges, including those not fully covered by insurance.

**AUTHORIZATION OF BENEFITS:**

I hereby authorize and request my insurance company to pay IBERIA PEDIATRICS directly for any benefits as described in the accompanying payment policy, but not to exceed the reasonable and customary charge for those services.

**CONSENT FOR MEDICAL CARE**

**CONSENT TO TREAT:**

Consent is hereby given, voluntarily and knowingly by the undersigned patient, (who if a minor, is joined in such consent by the undersigned parent or legal guardian to the performance of invasive and other procedures, treatments, blood tests, or examinations which I or my child or children may receive while patient(s) with **IBERIA PEDIATRICS INC**. from members of the medical and employee staff which they, or any of them, in their best judgment may deem proper for my best interest. I further authorize any and all other procedures or treatments the Clinic deems necessary in the best interest of patient(s) care. I hereby authorize disposal of any specimen taken from my body during my care.

I attest that I have read the above and am aware of its content and also that this consent covers all patient(s) / famly members listed on registration sheet.

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**SIGNATURE OF GUARANTOR/LEGAL GUARDIAN**