

**PEDIATRICS FIRST LLC**

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**CONSENT FOR SERVICES**

I, \_\_\_\_\_, (parent/guardian), give my permission to Pediatrics First to exchange information with the following physicians, insurance providers, programs, or other persons:

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about \_\_\_\_\_, whose date of birth is \_\_\_\_\_.  
(name) (DOB)

I also give permission for Pediatrics First to provide evaluation, treatment, and consultative services to the above-mentioned client.

I understand that fees for services provided are due at the time of treatment.

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(Parent/Legal guardian) (Date)

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(Witness) (Date)