# Arti Pediatrics

## CONSENT FOR TREATMENT OF A MINOR

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that Dr. Arti Jain believes are necessary. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers in this medical office to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent.

**Physician Licensing**

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, 800-633-2322, www.mbc.ca.gov.

**Financial Policy Acknowledgment**

I have read and understood the Arti Pediatrics Office/Financial policies.

**Privacy Statement Acknowledgment**

I have had the opportunity to review the Arti Pediatrics Privacy Practices.

**Travel Consultation Policy Acknowledgment**

I have read and understood the Arti Pediatrics Travel Consultation policy.

Signature _____ __ Print Name _____
Date _____