JELLISON INTEGRATIVE MD
HEALING • HEALTH • LONGEVITY

Jessica M Jellison MD / Paul D Reicherter MD / Amanda J Pierce APRN, FNP-C / Grace A. Keltner NP-C
Jellison Integrative MD, LLC
Minor/Child Consent for Medical Care

I understand that Jessica M Jellison MD has been specifically trained in Internal Medicine with a focus on adult care. I understand she was not specifically trained in pediatrics, but has branched out to see children during her integrative fellowship and current practice on a case-by-case basis.

Recognizing the need for medical care for the patient whose name appears on this form, I do voluntarily consent to such care encompassing routine diagnostic procedures and medical treatment by the medical staff of Jessica M Jellison MD / Paul D Reicherter MD / Amanda J Pierce APRN, FNP-C / Grace A. Keltner NP-C / Jellison Integrative MD, LLC and their assistants or designees as necessary.

I authorize payment of medical benefits to the Jessica M Jellison MD / Paul D Reicherter MD / Amanda J Pierce APRN, FNP-C /Grace A. Keltner NP-C / Jellison Integrative MD, LLC for services provided to the patient.

I accept full financial responsibility for services received by the patient which are not covered by government benefits or any type of insurance. I understand that possession of medical insurance does not relieve me of financial responsibility to Jessica M Jellison MD / Paul D Reicherter MD / Amanda J Pierce APRN, FNP-C /Grace A. Keltner NP-C / Jellison Integrative MD, LLC at the time of services. I also understand that I am responsible for obtaining all referrals or authorizations required by my insurance.

I, _____, parent or legal guardian of _____,

born _____ day of _____, 20____ do hereby consent to any medical care and encompassing routine diagnostic procedures and medical treatment by the medical staff of Jessica M Jellison MD / Paul D Reicherter MD / Amanda Pierce APRN, FNP-C/ Grace A. Keltner NP-C / Jellison Integrative MD, LLC and their assistants or designees as necessary for the welfare of my child.

_____ _____
Signature of Parent or Legal Guardian Date

_____
Relationship to Patient

_____ _____
Witness Signature Date

_____ _____
Clinic Date