

**Atlanta Children's ENT, P.C. Financial Policy  
Responsible Party Acknowledgement / Consent**

I as legal guardian for the minor child, \_\_\_\_\_, authorize Atlanta Children's ENT, P.C. and their health care providers to render medical care and treatment for the above named child.

I have been informed of the Financial Policies and my financial responsibilities to Atlanta Children's ENT, P.C. and agree to abide by all financial requirements contained herein.

Dr. White has ownership interest in Children's Healthcare of Atlanta Surgery Center at Meridian Mark Plaza, LLC, 5445 Meridian Mark Road, Suite 340, Atlanta, GA 30342 and at Atlanta Outpatient Pediatric Surgery Center, 5730 Glenridge Drive, Suite 300, Sandy Springs, GA 30328. Depending on your medical needs, you may be referred to the facilities listed above. Your ongoing care is not conditioned on your acceptance of this referral. You have the right to obtain the services from the facility to which you are referred or from a health care provider of your choice

**Date** \_\_\_\_\_

**Parent/Legal Guardian Signature** \_\_\_\_\_

**Parent/Legal Guardian Printed Name** \_\_\_\_\_

This form and any attachment may be electronically stored and a copy of the same, including your signature, shall serve as a substitute original for all purposes.