Primary Pediatrics, P.C.

Patient's Full Name: _____

Date of Birth: ____/____/_____

Authorization for Treatment

I, the undersigned certify that I (or my dependent) have insurance coverage as listed herein an assign directly to Primary Pediatrics, P.C. I understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of co-pays, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Primary Pediatrics, P.C. to release all information necessary to secure paymen of benefits. I authorize the use of this signature for all insurance claims.

IF I AM NOT AVAILABLE, THE FOLLOWING PERSON(S) ARE AUTHORIZED TO SEEK TREATMENT FOR THE ABOVE REFERENCED PATIENT:

The names listed below are the only people who will be able to bring your child to see the doctor A photo i.d. will be required the day of service for identification purposes.)

Name: _____ Relationship: _____ Phone Number: _____
Name: _____ Relationship: _____ Phone Number: _____
Name: _____ Relationship: _____ Phone Number: _____
Name: _____ Relationship: _____ Phone Number: _____
Name: _____ Relationship: _____ Phone Number: _____

Consent for Treatment

Having voluntarily presented myself (or my dependent) to Primary Pediatrics, P.C., I acknowledg ecognition of the fact that the evaluation and treatment received, advised or deemed necessar is entrusted to the judgment of the Physician.

Acknowledgement of Privacy Notice (HIPAA)

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Disclosure of Information

By signing this form, you acknowledge that Primary Pediatrics, P.C., has informed you of its Privacy Notice, which explains how your health information will be handled in various situations. We at Primary Pediatrics, P.C., value, and do everything in our power to protect, your privacy. Your medical information will not be given to any individual (including spouses, parents, children, or any significant others) without your written consent.

(Note: Uses and disclosures may be permitted without prior consent in an emergency.)

Date: _____ **Guardian's Name:** _____ **Guardian's Signature:** _____

(Please Print)