

CONSENT TO THE USE/DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights and responsibilities with respect to your health care information.

The Notice of Privacy Practices provides more detailed information about how Pediatric Physicians, Inc. may use and disclose health information. I have the legal right to review the Notice of Privacy Practices before I sign this consent, and Pediatric Physicians, Inc., encourages reading it in full. My signature below verifies that I have received the Notice of Privacy Practices. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I have the right to request how my health information is used and disclosed. I also have the right to restrict how this information is disclosed, but the practice is not legally required to agree to these restrictions. Pediatric Physicians, Inc. must receive requests for any restriction disclosure in writing.

I hereby authorize Pediatric Physicians, Inc., to release any information acquired in the course of my examination or treatment for the purposes of treatment, payment and healthcare operations. This information may be delivered in person, via regular mail, modem, telephone, or facsimile transmission. The information may be viewed by someone other than the intended recipient and I hereby release Pediatric Physicians, Inc., from any liability as a result of such transmission.

I have been informed and understand that Pediatric Physicians, Inc., will not bill third party payors (automobile/homeowners or other business insurances). I understand that all charges accrued by me must be submitted to my private health insurance (or paid for by me) and third party payors must settle privately with these individuals. I further understand that any unpaid balance is my financial responsibility.

I understand that I may revoke this consent in writing, but the revocation will not apply to any services given before the revocation was signed. I also understand that by refusing to sign this consent or revoking this consent, this practice may refuse all services.

CHECK ONE:

€ I authorize payment of medical benefits direct to Pediatric Physicians, Inc. I understand I am financially responsible for all charges not covered and guarantee payment of this account.

OR:

€ For the following reasons, I agree to be responsible for all bills incurred in the course of my examination and treatment

€ No insurance coverage in force at this time.

€ I do not wish to have Pediatric Physicians, Inc., bill my insurance company for me.

AUTHORIZATION TO DOWNLOAD MEDICATION HISTORY

By signing below, I am giving Pediatric Physicians, Inc., my consent to retrieve and use my medication history from SureScripts.

Patient Name

Date of Birth

Signature of Patient or Responsible Party

Date