**PATIENT NAME:_____ DOB:_____**

## CONSENT TO TREAT, INSURANCE ASSIGNMENTS, FINANCIAL AGGREEMENT, AUTHORIZATION TO RELEASE INFORMATION AND PRIVACY NOTICE ACKNOWLEDGEMENT

1. **CONSENT TO MEDICAL TREATMENT** The undersigned consents to the medical treatment and immunization schedule as recommended by the AAP, and is deemed advisable in the judgement of my physician or other provider at Pediatric Associates, LLC._____(initials)
2. **ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO REALEASE INFORMATION** In consideration of services rendered, I hereby transfer and assign to Pediatric Associates, LLC all rights, title and interest in any payment due for services rendered. Pediatric Associates, LLC may disclose all or any part of the patient's record as needed to obtain compensation for services. _____(initials)
3. **FINANCIAL AGREEMENT** The undersigned agrees, whether he/she signs as agent or patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of Pediatric Associates, LLC in accordance with the regular rates and terms of Pediatric Associates, LLC. _____(initials)
4. **MEDICAID** I certify that the information given to me in applying for payment under Title XIX of the Social Security Act is correct. I authorize that any holder of medical information about me to release to Social Security Administration/Division of Family Services or it's intermediaries any information needed to this or a related Medicaid claim._____(initials)
5. **USE OF COPIES** I permit a copy of the authorizations and assignments to be used I place of the original, which is on file at Pediatric Associates, LLC._____(initials)
6. **PAYMENT RESPONSIBILITY** If a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. I understand it is my responsibility to pay for any CO-PAY, DEDUCTIBLE, CO-INSURANCE OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE. _____(initials)
7. **OK TO LEAVE VOICE MAIL MESSAGE: ___Y ____N**

**NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT**

I have received Pediatric Associates, LLC, Notice of Privacy Practice.

Sign_____Date_____
Patient refused to Sign
Staff signature:_____

**OTHER THAN PARENTS, WHO CAN WE CONTACT FOR MEDICAL INFORMATION?**

NAME:_____PHONE:_____

DATE:_____ PATIENT'S SIGNATURE:_____

SUBSCRIBER SIGNATURE (if different than patient)_____