PEDIATRIC ASSOCIATES, PA

Patient Name: _____ **Account#:** _____

Payment Authorization

Whoever brings the child in is financially responsible for the visit. All fees not covered by insurance must be paid at the time services are rendered.

I hereby authorize payment of insurance benefits directly to Pediatric Associates. I understand I am financially responsible for any charges not paid by my insurance company.

I authorize Pediatric Associates to maintain my payment (debit card and / or credit card) information on file which can be used to pay for non-covered expenses such as co-payments, deductibles, health forms for school, work or athletic teams, and fees for missed appointments. The fee for a missed appointment is $25. I acknowledge that I have received the Missed Appointment Policy and can access the card on file policy on the website.

Authorization to Treat: We must have prior authorization in place so that medical care can be delivered directly to minors if/when a parent or legal guardian cannot be present prior to treatment. Please sign the authorization below. Please be advised that some protected health information may be shared with a non-custodial adult if they are accompanying the minor child.

I have the legal right to preauthorize and request that Pediatric Associates deliver medical treatment for my child. If the nature of the medical care is not routine, Pediatric Associates will attempt to contact me, however I understand that this authorization to treat is not contingent upon their ability to successfully make contact with me.

I understand that this consent to treat must be signed in order for my minor child to be seen and will be considered valid until such time that I revoke it in writing.

Patient Consent to the Use of Telemedicine: I acknowledge that I have read the Informed Consent for Telemedicine Services and that I am aware that a copy is available on the Pediatric Associates website and in the medical office. I understand that I will only receive a telemedicine consultation if I sign this authorization to treat for Telemedicine Services in advance of the consultation. This consent will be valid unless revoked.

Patient Consent to the Teaching/Training: I understand that Pediatric Associates may allow non-employees, such as students, interested physicians, health care industry or pharmaceutical representatives, access to the patient care areas. They may have direct or incidental access to PHI. I am aware and provide consent.

Patient Consent to Medication History Use: I understand that Pediatric Associates may request and use medication prescription history from other healthcare providers and/or third party pharmacy for treatment purposes.

Patient Acknowledgement of Notice of Privacy Practice: In accordance with the Health Information Privacy Rule, I authorize Pediatric Associates, Pediatric Associates of Tampa Bay and Jacksonville Pediatric Associates to release Student Immunization records upon request directly to my child's school initially and once the immunization records are updated. I understand that this authorization remains effective until revoked. I understand that in order to restrict disclosure of my child's immunization records to his / her school, I must request and complete HIPAA Form A – Restrict Disclosure of Immunization Records to Schools.

I acknowledge that I have received information on the Notice of Privacy Practices (NPP) and I am also aware that the NPP is available on the Pediatric Associates website www.pediatricassociates.com or in the office upon request.

_____ _____

Name of Legal Guardian Completing This Form Relationship to Child

List Other Legal Guardians:

_____ _____

Printed Name Relationship to Child

Printed Name	Relationship to Child
Printed Name	Relationship to Child
Printed Name	Relationship to Child

I acknowledge that I have declined to receive a copy of the Notice of Privacy Practices (NPP) _____

Initial

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