Metroplex Pediatrics, PA

Financial Policy, Assignment Information, and Release of Information

I authorize release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company or Medicaid on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor. I authorize (assign) any insurance or Medicaid benefits to be paid directly to Metroplex Pediatrics, PA or its assignees. I am responsible for non-covered services, supplies, co-payments or deductibles. I am responsible for knowing how my plan works, and I request medical services at this office. This acceptance and assignment will be in force for all future services by practitioners from this office.

_____ _____

Signature of Parent or Patient's guardian/representative Date

_____

Printed name of person signing above

Acknowledgment of Notice of Privacy Practices

I understand that as part of my healthcare, Metroplex Pediatrics, PA originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services bills were actually provided
- A tool for routine health care operations such as assessing quality

I understand that Metroplex Pediatrics, PA maintains a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. The most recent version of this notice is displayed in the waiting room area. I understand that Metroplex Pediatrics, PA reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional written copy of this notice at any time. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to request restrictions as to how my health information may be used or disclosed

I have had an opportunity to receive and review the *Notice of Privacy Practices* of Metroplex Pediatrics.

_____ _____

Signature of Parent or Patient's guardian/representative Date

_____

Printed name of person signing above

Patient Name:_____ DOB:_____