



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 Medicare 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 Medicare or Medicaid benefits to be paid directly to Pleasant Pediatrics PLC or its assignees. I am responsible for any non-covered services, supplies, co-payments, coinsurance 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.

Printed name of parent or guardian

Signature of parent or guardian

Date

Acknowledgement of Receipt of Notice of Privacy Practices

Pleasant Pediatrics is required to provide you with a copy of its Notice of Privacy Practices stating how it may use and/or disclose your health information. This form acknowledges receipt of this notice. The most recent version of this notice is posted in the waiting room area.

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, and
- 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 Pleasant Pediatrics PLC.

Printed name of parent or guardian

Signature of parent or guardian

Date

Consent for Medical Treatment

I hereby give consent for medical treatment of my children who are minors (Please list all children):

I grant my permission for treatment at Pleasant Pediatrics PLC, by a licensed physician, licensed nurse practitioner, licensed physician assistant, and/or designees, including such personnel as the physician may deem necessary. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment.

- I am giving permission to leave lab & other results on voicemail for the following number(s):**

Phone #1: _____ Phone#2: _____ Phone#3: _____

- I am giving permission for the following adults to bring my child for treatment:**

This consent will be in effect from this date until the above minors are 18 years of age unless cancelled earlier by me in writing.

Printed name of parent or guardian

Signature of parent or guardian

Date