sound pediatrics

**PATIENT NAME** _____ **DOB** _____

## CONSENT FOR TREATMENT AND AUTHORIZATION FOR PAYMENT

**MEDICAL CONSENT:** I understand that I am seeking medical care for my self or my child at Sound Pediatrics. The type and extent of services that he/she will receive will be determined by a licensed physician following an initial assessment and thorough discussion with me. I am consenting to any medical treatment or procedures which may include medical and minor surgical treatment, x-ray, laboratory, immunizations and other medical services that are necessary or advisable in the interest of my child's wellbeing.

**FINANCIAL AGREEMENT:** I certify that the information given for payment under government or private insurance is correct. I understand that I am financially responsible to Sound Pediatrics for all co-payments, deductibles and co-insurance. In the event that I have no insurance or my insurance does not cover products and services provided to me, I am financially responsible to pay for these products and services, which may include fees for medical supplies. Sound Pediatrics reserves the right to impose reasonable finance and late charges as well as reasonable cost and expenses incurred in the collection of my account if it becomes delinquent.

**ASSIGNMENT OF INSURANCE BENEFITS:** I authorize Sound Pediatrics to request on my behalf and to collect directly, all public and private insurance coverage benefits (including Medicare, if applicable) due for products and services supplied by Sound Pediatrics.

**RELEASE OF HEALTH INFORMATION TO PAYERS**: I authorize Sound Pediatrics to release any health care information necessary to facilitate the processing of claims or audit of payments relative to the services provided to me or my child by Sound Pediatrics.

By signing below I am acknowledging full understanding of the above notice and hereby indemnify and hold harmless the physicians, medical office and other persons who act in reliance upon this authorization.

Signature _____ Date _____ Relationship (if other than patient) _____

## MISSED APPOINTMENT POLICY

We understand there will be circumstances that may require you to cancel your appointment. If you will not be able to keep a scheduled appointment, please notify our office within 24 hours so we can use that appointment for another patient. If by chance you forget your appointment and do not call to cancel your appointment, you will be charged a $50 missed appointment fee. As a courtesy, appointment reminder calls are made 24-48 hours prior to your scheduled appointment. Please provide us with the best possible number to contact you for appointment confirmation.

Your signature below indicates that you have read and understood cancellation policy. If the patient is a minor, the parent or legal guardian whose signature appears below is responsible for the charge.

Signature _____ Date _____ Relationship (if other than patient) _____

Best contact number for appointment reminders _____ Cell ☐ Home ☐ Work ☐

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Federal law, commonly known as HIPAA (Health Insurance Portability and Accountability Act) requires we take additional steps to keep you informed about how Sound Pediatrics may use information that is gathered in order to provide health care services to you. As part of this process, we are required to provide you with our Notice of Privacy Practices and to request that you sign below to acknowledge that you have received a copy of the Notice. The Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This notice also describes your rights regarding health information we maintain about your and a brief description of how you may exercise these rights.

Your signature below indicates that you have received the Notice of Privacy Practices of Sound Pediatrics.

Signature _____ Date _____ Relationship (if other than patient) _____