Authorization to treat and release information

Request for Medical or Surgical Services

I have requested medical services from PEDIATRICS OF GREATER ORLANDO, PA on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that I am responsible for any amount not covered by insurance.

Authorization to Render Care and Financial Responsibility

I authorize PEDIATRICS OF GREATER ORLANDO, PA to render medical care to my child, and I understand that all visits are to be paid at the time of service. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to PEDIATRICS OF GREATER ORLANDO, PA for medical or surgical services rendered to myself and/or my dependents regardless of my insurance benefits, if any.

Authorization to Release Information

I hereby authorize PEDIATRICS OF GREATER ORLANDO, PA to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime; and (4) in order to carry out treatment, or health care operations. This order will remain in effect until revoked by me in writing.

You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form. We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff. You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to releasing information to me in the following manners:

	PLEASE INITIAL
VIA MAIL	
☐ OK TO MAIL TO HOME ADDRESS	_____
☐ OK TO MAIL TO WORK ADDRESS	_____
VIA HOME TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA WORK TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA FAX	
☐ OK TO FAX TO: _____	_____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ Date: _____

_