CONSENT FOR TREATMENT AND AUTHORIZATION FOR PAYMENT

MEDICAL CONSENT: I consent to receive evaluation, care, and treatment from providers working at Bainbridge Pediatrics. I understand such services may include examination, medical and minor surgical treatment, x-ray, laboratory, immunizations and other medical services performed or prescribed. I am aware that the practice of medicine is not an exact science, and acknowledge that no guarantee or promises have been made as to the result of treatment or examination.

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 Bainbridge Pediatrics for all co-payments, deductibles, and coinsurance. In the event that I have no insurance, or my insurance does not cover products and service provided to me, I am financially responsible to pay for these products and services, which may include fees for medical supplies, after hours and emergency office visits, home visits, missed appointment fees and after-hours phone call charges. Bainbridge Pediatrics reserves the right to impose reasonable financing and late charges as well as reasonable cost, attorney fees and expenses incurred in the collection of my account if it becomes delinquent. Financial responsibility may be waived or reduced if charity care eligibility is determined.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize Bainbridge 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 Bainbridge Pediatrics. In the event that insurance benefits are paid directly to me, I will endorse to Bainbridge Pediatrics all checks for such payments.

MEDICARE CERTIFICATION (when applicable): I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

RELEASE OF HEALTH INFORMATION TO PAYERS: I authorize Bainbridge Pediatrics to disclose my health information to my insurers, including the Center for Medicare and Medicaid Services or its representatives if applicable, and others financially responsible for payment, auditing, and coordination of insurance claims

RELEASE OF INFORMATION:

NOTIFICATION: A family member, personal representative, or other person responsible for my care may be notified of my location, general condition, or death.

DISASTER RELIEF INFORMATION: Bainbridge Pediatrics may also disclose information to assist in disaster relief efforts.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received Bainbridge Pediatrics' Notice of Privacy Practices. INITIAL_____
State why patient could not initial: ☐ child ☐ under guardianship ☐ unconscious
☐ Incapacitated ☐ _____

Patient Name: _____

_____ _____
Signature of patient or legally responsible party Date

Patient DOB: _____

_____
Relationship to patient, if not signed by patient

State why patient could not sign themselves:_____
☐ child ☐ under guardianship ☐ unconscious ☐incapacitated