I request that payment of authorized benefits be made to

I further authorize the release of any medical information necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities or any healthcare professional requiring this information.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial obligation for all medical fees and charges incurred by me or my child/ren and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to Intown Pediatric & Adolescent Medicine, PC by any insurance policy, self-insurance program or other benefit plan.

This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Parent/Guardian _____ Date_____

Relationship to patient_____

ALTERNATIVE CONTACT AUTHORIZATION

I do ☐ I do not ☐ authorize you to contact or leave messages at my place of work.

I do ☐ I do not ☐ authorize you to contact me at my e-mail address.

I do ☐ I do not ☐ authorize you to leave messages on my home answering machine regarding appointments and to inform me that laboratory results are available. **Laboratory results are NEVER left on the answering machine. You must call the office to receive them.**

Parent/Guardian _____ Date_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

This is to acknowledge that I have received or seen a copy of the office's Notice of Privacy Practices.

Parent/Guardian _____ Date_____

REFERRAL SOURCE

How did you hear about us? (please circle one)

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