Clinical Pediatric Associates of North Texas

ACKNOWLEDGEMENT

Please initial at EACH LINE below as you read.

_____I have carefully read the office and financial policies of Clinical Pediatric Associates of North Texas (CPANT), understand and agree to the terms and conditions as stated.

_____I have received a copy of the office and financial policies of CPANT.

_____If CPANT files insurance in my dependents behalf, I understand I am financially responsible and agree to pay for non-covered services, co-insurance, co-pays and deductibles.

_____I accept legal responsibility for all expenses in treating the patient/patients named below and understand that payment for services is due at the time they are rendered.

_____I have received a copy of the Privacy Practices.

_____I understand that CPANT reserves the right to modify the Privacy Practices without prior notice.

_____I understand that I can request a copy of the updated Notice of Privacy Practices by calling the CPANT office or requesting a copy in person at my appointment.

_____

Patient(s) Name

_____ _____

Responsible Party's Signature **Date**

□ Patient is 18 years old or older.

_____ _____

Patient Signature if 18yrs or older **Date**

AUTHORIZATION TO RELEASE INFORMATION

I authorize Clinical Pediatric Associates of North Texas (CPANT) to release any of my medical information to:

_____Insurance company(s) as needed to process any claims, to pay CPANT directly for covered medical and/or surgical services.

_____Other than the Parents/Guardians of the patient, I would like the below names to be involved in or have access to the patient's protected health information on a routine basis. I give permission for Clinical Pediatric Associates of North Texas to share the protected health information with:

_____ _____

Name Relationship Name Relationship

_____ _____

Name Relationship Name Relationship

****Please fill out a CONSENT TO TREATMENT OF A MINOR for each person named above****

_____

Patient(s) Name

_____ _____

Responsible Party's Signature **Date**

_____ _____

Patient Signature if 18yrs or older **Date**