Clinical Pediatric Associates of North Texas

ACKNOWLEDGEMENT

Please initial 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 on my dependent(s) 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(s) 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 outlined in the notice.

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

_____

Patient(s) Name

_____ _____

Responsible Party's Signature **Date**

AUTHORIZATION TO RELEASE INFORMATION

I authorize 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.

_____The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for CPANT to share my protected health information with:

_____ _____

Name Relationship Name Relationship

_____ _____

Name Relationship Name Relationship

_____

Patient(s) Name

_____ _____

Responsible Party's Signature **Date**