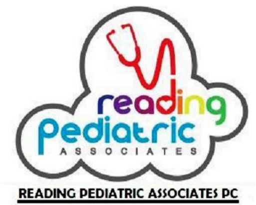

I - CONSENT FOR MEDICAL TREATMENT

I do hereby voluntarily consent to Reading Pediatric Associates PC the care and related medical treatments as necessary. I understand that this consent may be revoked by me any time writing.

II - AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the practice and physicians to release any medical information required in the processing of applications, submission of financial coverage, discharge planning, and further medical treatment in line with the new Omnibus HIPAA rule and as stated in the Notice of Privacy Practices.

III – AUTHORIZATION TO BE CONTACTED VIA PREFERRED METHOD

I authorize contact from this office to confirm appointments, treatment, billing information, and convey information about my health via: (Check all that apply)

☐ Cell Phone ☐ Text Message ☐ Web View
☐ Home Phone ☐ Work Phone ☐ All of the Above

IV – AUTHORIZATION FOR ACCESS TO MY MEDICAL RECORDS

Please list any other parties who can have access to your or your child's health information: (This includes stepparents, grandparents and any caretakers)

I grant access to:____

V - ASSIGNMENT OF INSURANCE BENEFITS

I request payment of authorized benefits be made on my behalf to Reading Pediatric Associates PC for services rendered to me, or my child by this practice. I understand that I am financially responsible for charges not covered by this authorization or by charges not covered due to my failure to provide my correct insurance information. I acknowledge that I am responsible to name Reading Pediatric Associates PC or one of the physicians in the group as my Primary Care Provider prior to my visit and failure to do so will leave me responsible for any unpaid claims by my insurance. I also understand that co-payments are to be made at the time of visit.

VI – NO SHOW & CANCELLATION POLICY

I have been made aware of the "NO SHOW" & "CANCELLATION" policies and agree to notify the office 24 hours prior to the appointment if I'm unable to keep it. Failure to do so will result in a $25 fee.

VII – ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I read or was offered a copy of the "Notice of Privacy Practices". The notice describes how my health information will be used or disclosed. I understand this notice should be read carefully and that it can be changed at any time. I am also aware that a copy is available on-line to read at www.readingpediatrics.org.

Patient's Name: ______________________________ DOB: ______________
Patient's Name: ______________________________ DOB: ______________
Patient's Name: ______________________________ DOB: ______________
Patient's Name: ______________________________ DOB: ______________

____ Date:______________
Patient (or Responsible Party's) Signature