



Pediatrics of Okaloosa P.A.

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1001 West College Blvd., Suite C - Niceville, Florida

Name: _____

Date of Birth: _____

Consent for treatment *and to the* Use & Disclosure of Health Information for Treatment, Payment, or Healthcare Operation

Consent to Treat:

I am the parent or legal guardian for the patient listed above and I authorize Pediatric of Okaloosa to evaluate and treat and to release to the insurance company any information acquired in the course of their examination or treatment, and to receive all payments for such examination or treatment, Pediatric of Okaloosa has my permission to release any diagnostic studies, reports, etc. to a specialist involved in their care. _____initial

I understand that as a part of **my child's** healthcare, Pediatrics of Okaloosa, will originate and maintain health records that describe my child's history, symptoms, examination, test results, diagnoses, treatment, and plans for future care or treatment.

I understand that these health records serve as:

- A basis for planning my child's care and treatment
- A means of communication among the many health professionals who contribute to my child's care
- A source of information for applying my child's diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- *We will file your claim with your insurance as a courtesy, all claims unpaid after 60 days become the responsibility of the patient to be paid in full.* _____initial

I understand and have been provided/offered a copy of the Notice of Information and privacy practices which provides a more complete description of information uses and disclosures. I understand that Pediatrics of Okaloosa reserves the right to change its notices and practices. If changes are made Pediatrics of Okaloosa will notify me. I may request restrictions in writing. I understand and accept the above information.

Signature-Mother-Father-Guardian (Circle one)

Primarily responsible for medical decisions

Date

Authorized to make medical decisions

Home Phone

Cell Phone

Signature-Mother-Father-Guardian (Circle one)

Primarily responsible for medical decisions

Date

Authorized to make medical decisions

Home Phone

Cell Phone