Pediatrics of Okaloosa P.A.

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Name: ____

Date of Birth: ____

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

I authorize Pediatric of Okaloosa to evaluate and treat me and to release to my insurance company any information acquired in the course of my 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 my care. _________Initial

I understand that as part of **my healthcare**, Pediatrics of Okaloosa, originates and maintains health records that describe my history, symptoms, examination, test results, diagnoses, treatment, and plans for future care or treatment. I understand that these health records serve as:

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- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my 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	Date	Home Phone	Cell Phone

Parents can be called (Y) (N)