PEDIATRICS WEST, P.C.

18+

ADULT OR MATURE/EMANCIPATED MINOR PATIENT
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
PLEASE PRINT CLEARLY

Patient's Name: _____
First MI Last

Patient's Date of Birth: _____ Patient's Primary Phone #: _____

Patient's Address: _____

_____
(City) (State) (Zip)

Patient's e-mail: _____

Patient's Primary Care Physician _____

ACKNOWLEDGEMENT OF RECEIPT OF PEDIATRICS WEST'S (the "PRACTICE") NOTICE OF PRIVACY PRACTICES:
By my signature below, I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION:
By my signature below, I hereby authorize the Practice to disclose my medical information so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g., quality assurance). I also authorize the Practice to disclose my medical information to insurers and providers outside of the Practice when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations.

I authorize the Practice to disclose my medical information on (check one):

☐ My Primary phone voicemail or ☐ Other method, describe_____

I authorize the Practice to disclose my health information to the following family members/friends (I understand I may instruct Pediatrics West, P.C. to limit disclosure of my health information to family members and/or their insurance plans but by doing so my family's health plan cannot be billed for my visit or test and I shall be financially responsible to pay all charges directly):

☐ None

_____	_____	_____	_____
Name	Relationship to Patient	Name	Relationship to Patient
_____	_____	_____	_____
Name	Relationship to Patient	Name	Relationship to Patient

ASSIGNMENT OF INSURANCE BENEFITS:
By my signature below, I authorize medical benefits to be paid to Pediatrics West, P.C. on my behalf for any service provided by the medical and clinical staff of the practice. I understand that I am responsible for all charges, regardless of insurance coverage, for this service date as well as all future service dates.

ASSIGNMENT OF RECEIPT OF PRACTICE'S BILLING POLICY:
By my signature below, I hereby acknowledge that I have received a copy of the Pediatrics West Patient Policies.

_____	_____	_____
Signature	Relationship to Patient	Today's Date (MM/DD/YYYY)

_____
Print Name