Notice of Privacy Practices, Consent for Care, and Financial Responsibility Acknowledgement

Privacy Practices – We maintain a record of the health care services that we have provided to you. We will share this information, as permitted by law, to provide your medical treatment, run our organization, and bill for these services. You have the right to view, obtain a copy, or amend the record if needed.

Our **Notice of Privacy Practices** describes in more detail your rights to your health information and how this information may be used and disclosed. Sharing of your health information is typically used to improve the continuity of care that you receive. Common examples include sending immunization records to our state registry, use of a Health Information Exchange (HIE) with other health care organizations involved in your care, and accessing your prescription history from pharmacy benefits. If you have questions or want to discuss options for decreased information sharing, please contact us.

Consent for Care – I hereby authorize West End Pediatrics,PLLC to institute any necessary care in my absence, including hospitalization, for the child listed below.

Financial Responsibility – I hereby authorize payment directly to the provider for services rendered for any benefits available under my insurance, and I am financially responsible for non-covered services rendered. For well child checkup visits, these may include charges for services that are provided in addition to typical routine checkup care.

By my signature below:
I acknowledge receipt of the Notice of Privacy Practices and Information about Well Care Appointment Charges, Sick visits or consultations and authorize consent for care, and accept financial responsibility for the patient listed below. This form must be signed by a parent or guardian if the patient is under the age of 18.

Patient Name _____ Patient Date of Birth _____

Signature of patient or parent/guardian if patient is under 18 _____

Printed Name of Person Signing _____ Date _____ Relationship to Patient _____

Insurance Subscriber's Printed Name _____ Insurance Subscriber's Date of Birth _____ Relationship to Patient _____

This form will be retained in the patient's medical record.