FRENCH BROAD PEDIATRICS

PATIENT DISCLOSURES & CONSENTS

NAME:_____

DATE OF BIRTH:_____

Assignment if Insurance Benefits:

I hereby authorize direct payment of my insurance benefits to French Broad Pediatrics for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services are a covered benefit. I understand and agree that I will be responsible for any co0pay or balance due that French Broad is unable to collect from insurance carrier for whatever reason.

Medicare/Medicaid/Champus Insurance Benefits:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release if any of my or my dependent's records that these programs may request. I hereby direct that payment of my dependent's authorized benefits be made directly to French Broad Pediatrics on my behalf.

Authorization To Release Non-Public Personal Information:

I certify that I have received and read a copy of the French Broad Pediatrics Patient Information Privacy Policy. I hereby authorize French Broad Pediatrics to release any of my or my dependent's medical or incidental non-public personal information that mat be necessary for medical evaluation, treatment, consultation, it the processing of insurance benefits.

Lab/X-ray/Diagnostic Services:

I understand that I may receive a separate bill if my medical care includes lab, x-rays, or other diagnostic services. I further understand that I am financially responsible for any co– pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

Consent to treatment:

I hereby consents to evaluation, testing, and treatment as directed French Broad Pediatrics.

Patient or Guarantor Signature:_____ Date:_____

Guarantor Name (please print):_____