Partners in Pediatrics & FAMILY HEALTH

"no such thing as a dumb question"

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Phone 301-791-7060 ▪ Fax 301-791-8990

General Consent/Authorization Form

***Year: _____**

Please answer **all Questions **honestly**; your answers will be kept confidential. If you are dishonest in your answers, you will be discharged as a patient from our practice.*

***Today's Date: _____* Current Cell Phone#: _____**
***Patients Name: _____ *Date of Birth: _____ *Email Address: _____**
Please read carefully:

- All charges (co-pay, deductibles, self-pay, etc) are **due at the time professional services are rendered**.
- For those services provided and submitted to my insurance company, I hereby authorize the payment of medical benefits to Partners In Pediatrics and Family Health, here in after known as PIPFH (DEJ Med Practice LLC.)
- The patient is responsible for all fees.
- The fee ticket may be used to file insurance claims.
- For minors: I understand that I am fully responsible for this minor's medical charges and agree to pay all charges for services rendered by PIPFH.
- I hereby authorize PIPFH to furnish information to any insurance company or authorized agency Specified, regarding information concerning my medical care.

Consent for Treatment: I authorize providers at PIPFH to perform examinations, procedures, laboratory tests and to administer such medication as; in his/her opinion is necessary for my care.
Patient / Guardian's signature (for minors): *_____ * Date: _____

Consent for Medication History: I consent to the use of my medication history from any participating medical information exchanges.

Ancillary Services: I understand that PIPFH and other independent labs may be performing laboratory studies as ordered by my physician and collected at PIPFH. These studies will be billed to me by PIPFH lab. I understand that my insurance may not cover these services, and that I am fully responsible for these charges.

Release of Information: Often it is difficult to reach a patient to convey physician orders or test results. In this event, with your signed authorization, we would release such information to the person you designate. Please complete the section below.

Consent to Release of immunization records to other Organizations/Schools: *Yes ( ) No ( ).
*Organizations/School Name (s): _____

Receipt of Notice of Privacy Policy**: I have received/reviewed ( ) or declined ( ) a copy of the Notice of Privacy Policy titled: "Your information. Your rights. Your responsibilities".**

I authorize PIPFH to release any information required in the course of my examination or treatment to the following designated persons:

*Name: _____ *Name: _____
*Relationship: _____ *Relationship: _____
*Current Phone #: _____ *Current Phone#: _____

*Patient Signature: _____ Date: _____
*Guardian's Signature (**for minors**): _____ Date: _____