Town Center Pediatrics

Authorization & Acknowledgement Form

Patient Name: ____ DOB: ______________

ASSUMPTION OF RESPONSIBILITY: I, the undersigned, have read and fully understand the financial policy. I understand that I am responsible for this account regardless of the presence or absence of any medical insurance, divorcee decree, or separation agreement. By affixing my signature below, I understand and agree that I am responsible for all charges upon this account.

ASSIGNMENT OF INSURANCE: I authorize Town Center Pediatrics to release any medical information required by my insurance company or its designated claims processing agent in order to obtain payment of claims submitted on my behalf. I certify that the information I have reported with regard to my insurance coverage is correct.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I acknowledge that I have read a copy of Town Center Pediatrics notice of privacy policies. I consent to Town Center Pediatrics use of protected health information as described in the notice for treatment, payment, or health care operations. I understand that I must provide a separate authorization before any other disclosures may be made.

I agree to Town Center Pediatrics policies and to notify of any changes in my billing address, telephone number and/or my insurance information. This entire authorization is valid for all episodes of care rendered at Town Center Pediatrics.

By signing below I have read and understand all the information described above.

	Signature	**Printed name**	**Date**
2019			
2020			
2021			
2022			