Pediatric Associates of Westmoreland
Acknowledgement of Receipt of Notice of Privacy Practices/Consent to Treat

I, _____, the parent/legal guardian of the below named child

Name of Child	Date of Birth	Sex
_____	_____	_____

hereby authorize and consent to the examination and/or treatment of my child during office and facility visits by the physicians and clinical staff of Pediatric Associates of Westmoreland. I acknowledge that I have received the Notice of Privacy Practices for Pediatric Associates of Westmoreland. In addition, I give permission for the following person(s) to bring my child to PAW in my absence and to act in my behalf in authorizing medical care and treatment that may be involved in the healthcare of the patient. In the event of emergency or other illness, I understand that the physicians and staff of PAW will deliver any medical care deemed necessary regardless of the accompanying adult.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Authorization to Bill Insurance

Insurance Name: _____

Policy Holder Name: _____

Insurance ID: _____

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize Pediatric Associates of Westmoreland to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I further understand that excessively overdue accounts may be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that this authorization shall remain valid for (1) year of date signed.

Patient/Parent/Guardian Signature: _____

Date: _____

*********BELOW IS FOR PEDIATRIC ASSOCIATES USE ONLY*********

I have offered the above named patient/representative with the Pediatric Associates of Westmoreland Notice of Privacy Practices and they have accepted_____ or refused_____ delivery (and/or patient/representative was asked to sign form and refused_____)

_____	_____
Signature of Pediatric Associates Representative	Today's Date

02/21/2017

AUTHORIZATION FOR VACCINES

Childs Name: _____ DOB: _____

I _____ give permission for the following named person(s) to consent to vaccines or sign a refusal to vaccinate form on my behalf if I am not present for the appointment. If parents/ legal guardians are the only one that is capable of making these decisions please indicate below by marking "none" on the first line.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Parent/ Guardian Signature Date

_____ _____

Witness Date