Texoma Pediatrics

Consent for Services

Patient Name_____ **Date of Birth**_____

AUTHORIZATION FOR TREATMENT:
I authorize Texoma Pediatrics, PLLC to provide treatment to myself or the above named patient.

NOTICE OF PRIVACY PRACTICES:
I have been given a copy of Texoma Pediatrics, PLLC Privacy Practices in compliance with HIPAA legislation.

ASSIGNMENT OF BENEFITS:
I authorize my insurance company to pay and hereby assign directly to Texoma Pediatrics, PLLC, all benefits, if any, otherwise payable to me for services. This authorization may be revoked by either me or my insurance company at any time in writing.

REFERENCE LABORATORY SERVICES:
I understand that Texoma Pediatrics, PLLC utilizes the services of an outside lab to perform some of the lab tests requested by its physicians. I further understand that the Reference Laboratory will bill separately for its services. I consent to Texoma Pediatrics providing demographic information as necessary for billing purposes.

CANCELLATION OF APPOINTMENTS
I understand that I must give a 24 hour notice to cancel my appointment. I further understand that future services may be denied if I fail to keep my scheduled appointments.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:
I authorize release of copies of pertinent medical records to providers outside of Texoma Pediatrics, PLLC who are being consulted with and/or I am being referred to in connection with my current treatment, to insurance companies for the purpose of determining benefits for services provided, and to reference laboratories for billing purposes.

FINANCIAL POLICY/PAYMENT AGREEMENT/COLLECTION POLICY:
I, the undersigned, do hereby expressly guarantee payment of all charges for medical services rendered, or to be rendered by Texoma Pediatrics, PLLC. I understand that it is my responsibility to provide Texoma Pediatrics with current insurance information. I will be responsible for the balance due, plus any costs that are incurred by Texoma Pediatrics, PLLC in collecting my account.

USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION
My insurer may share my past, current and future health and account records with Texoma Pediatrics, PLLC about services I've received from Texoma Pediatrics, PLLC and other care providers unrelated to Texoma Pediatrics, PLLC. These records may be used by Texoma Pediatrics, PLLC as needed to manage or coordinate my care and to improve the quality of that care.

By signing this form, I am consenting to treatment and agreeing to these policies. I understand this authorization will remain in effect until I revoke it in writing.

_____	_____	_____
Date	Signature Patient (if 18 yr.) / Parent / Legal Guardian	Relationship to Patient