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:_____

Patient Address:_____ City:_____ Zip code:_____

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. For patients who reside with only one parent or guardian/foster care/non-biological caregivers, a current custody agreement must always be on file to ensure proper contacts.

Name: _____ Relationship: _____ Phone #:_____

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Our offices use our Electronic Medical Records (EMR) system to notify patients of upcoming appointments, and remind you of routine well visits, etc. Please tell us how you want to be notified, either by phone and/or email. The EMR system will attempt to reach contact number 1 first and then attempt contact number 2 if contact number 1 cannot be reached.

Contact number 1:

Name:_____ Your preference: text or email (circle)

Phone number:_____ and/or email:_____

Contact number 2:

Name:_____ Your preference: text or email (circle)

Phone number:_____ and/or email:_____

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.

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

Revised 12/16/2021