PEDIATRIC ASSOCIATES OF RICHMOND, INC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES/18 YR CONSENT FORM

Name: ____ Date of Birth:______________

Last First Initial

Cell Number:___________________

PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION: I authorize Pediatric Associates of Richmond, Inc (“PAR”) and its agents to release/discuss my protected health information to the following individuals:

Name	Relationship
___________________________	____________________________
___________________________	____________________________
___________________________	____________________________

ASSIGNMENT OF INSURANCE BENEFITS:

By signing below, I authorize medical benefits to be paid to PAR on my behalf for any service provided by the medical and clinical staff of the office. I understand that I am responsible for all charges, regardless of insurance coverage, for this service date as well as all future service dates.

ACKNOWLEDGEMENT OF RECEIPT OF PAR’S NOTICE OF PRIVACY PRACTICES:

By my signature below, I hereby acknowledge that I have received a copy of PAR’S Notice of Privacy Practices.

Print Patient Name:____________________________ Date:_____________

Patient Signature:_____________________________

(Office use only : 18yr consent on file-Warning note/Chart Alert/Employer section/Contacts/Scan)