Patient Authorization

Please read, initial, and sign below.

(Initial)_____ **Financial Policy**: I acknowledge that I received, reviewed, and agree to comply with the most recent version of the ABCD Pediatrics Financial Policy dated July 1, 2015.

(Initial)_____ **Financial Responsibility**: I understand that I am ultimately responsible for payment on my child's/children's account. Payment is expected at the time of service. I understand I am responsible to pay my co-pay, co-insurance, or deductible according to my insurance contract at the time of service.

(Initial)_____ **Insurance Coverage**: I understand that I am responsible to provide ABCD Pediatrics with my current insurance coverage information and insurance card at each and every visit. I will be responsible for paying any balances due as a result of not providing my most current insurance information. I understand that ABCD Pediatrics will not retroactively file claims due to my failure to provide current insurance information.

(Initial)_____ **Assignment of Benefits**: I hereby authorize payment directly to ABCD PEDIATRICS, for medical benefits otherwise payable to me. I authorize my insurance company to disclose to ABCD PEDIATRICS, information regarding my insurance coverage, including, but not limited to verification of my examination and/or treatment to my insurance company and/or other third party payor.

(Initial)_____ **No Show Fee**: I acknowledge that I received, reviewed, and agree to comply with the ABCD Pediatrics No Show Policy and agree to pay any fees incurred from failure to comply.

(Initial)_____ **Fee for Forms**: I understand that I received notice about the fee for all forms to be completed by ABCD Pediatrics and I agree to pay prior to form completion.

(Initial)_____ **Privacy Policy**: I acknowledge that I received, reviewed, and agree to comply with the ABCD Pediatrics Privacy Policy.

(Initial)_____ **Immunization Policy**: I acknowledge that I received, reviewed, and agree to comply with the ABCD Pediatrics Immunization Policy.

(Initial)_____ **Consent to Treat:** I have the legal right to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that providers of ABCD Pediatrics believe are necessary for my child. I understand that by signing this form, I am giving permission to the doctors, nurses, and other healthcare providers in this medical office to provide treatment to this child as long as my child/children are a patient in this practice.

(Initial)_____ **E-Prescribing:** I voluntarily authorize ABCD Pediatrics to allow E-Prescribing for patient's prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history as long as this child is a patient at this office.

(Initial) _____I understand I am able to withdraw my consent at any time by contacting ABCD Pediatrics in writing at 19238 Stonehue, San Antonio, TX 78258.

Patient Name: _____ DOB: _____

Siblings: _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Parent/Guardian name (Print): _____

Parent/Guardian Signature: _____

Today's Date: _____