ABCD Pediatrics

Patient Authorization

Please read, initial, and sign below.

(Initial)________**Financial Policy**: I acknowledge that I received, reviewed, and agree to comply with the ABCD Pediatrics Financial Policy dated January 1, 2019, including the Financial Responsibility and Insurance Coverage polices found within.

(Initial)________**Credit Card on File:** I understand that by providing my current credit card information to ABCD Pediatrics that I am authorizing it to be charged for any balance remaining after all insurances on file have been billed and processed.

(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/Walk-In Fee**: I acknowledge that I received, reviewed, and agree to comply with the ABCD Pediatrics "No Show Policy" and "Walk-In Policy" 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 so long as this child is a patient at this office.

((Initial)________**Recording/Photo Policy:** ABCD Pediatrics does not permit recording devices in the exam room or common areas. Our staff and other patients have the right to their image and likeness; therefore, we do not allow recording or photos of any kind during the visit. I understand the policy and agree to comply.

(Initial)________**Code of Conduct:** I acknowledge that I received, reviewed, and agree to comply with the ABCD Pediatrics Patient/Parent Code of Conduct.

Initial)________I understand I can withdraw my consent at any time by contacting ABCD Pediatrics in writing at 19238 Stonehue, San Antonio, TX 78258. Withdrawal may result in dismissal from the practice.

Patient Name:________________________________ DOB: _________________ Pat #: _________________

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Patient Name:________________________________ DOB: _________________ Pat #: _________________

Patient Name:________________________________ DOB: _________________ Pat #: _________________

Parent/Guardian name (Print): ____

Parent/Guardian Signature: ____

Today's Date: ____