Williamsville Pediatrics, LLP

Patient Authorization and Acknowledgement of Practice's Financial and Privacy Policies

In general, The HIPPA Privacy Rule (Heath Insurance Portability and Accountability Act of 1996 - a Federal law) gives individuals the right to request a restriction of uses and disclosures of their Protected Heath Information (PHI). It also provides the right to request confidential communications between an individual and his/her physician's office.

In order to protect your privacy and in keeping with the Federal Privacy Law, all of your medical information. PHI, is kept strictly confidential. We will use this PHI for Treatment, Payment and Operation (TPO) of our medical practice. We will be required to get an authorization in writing from you if we intend to use your PHI for any other purpose.

We have also put together a detailed Financial Policy governing your and our responsibilities. A copy of this Policy is attached and must be reviewed prior to treatment.

Authorization:

I authorize the release of any PHI necessary to determine liability for payment and to obtain reimbursement on any claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled, including, but not limited t, Medicaid/Medicare, private insurance and other Heath management organization to the practice named on this form.

This assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I also give permission to the providers and nurses of Williamsville Pediatrics, LLP to treat, perform any diagnostic procedures, and to administer vaccines in the medical care of my child(rens). I also authorize the release of my child (rens) medical information for completion of school forms, camp forms, working papers, sports physicals, etc. while under the care of Williamsville Pediatrics, LLP.

I authorize Williamsville Pediatrics, LLP and the practice staff to leave medical information pertaining to my care by the following methods;and I will assume the responsibility of notifying the office whenever this information changes. Please indicate below how you would like our office to handle communications with you:

Permission to contact me or leave a message:

Home telephone _____ yes _____ no _____number
Home Answering Machine _____ yes _____ no _____number
Work Telephone _____ yes ____ no _____number
Work Voicemail _____ yes ____ no _____number
Cell Phone/Pager _____ yes _____ no _____number

I agree to the insurance assignments and financial responsibilities as indicated by Williamsville Pediatrics, LLP Financial Policy. I am also aware of my rights and the practice's responsibilities with respect to Private Heath Information (PHI) as outlined in Williamsville Pediatric Associates', LLP Notice of Privacy Practices.

Patient's name (s) Please Print _____

Signature (Patient or Parent if Minor)
_____Date_____