



General Agreement to Use and Disclose Protected Health Information

Please initial next to each statement.

_____ I have received, read, and understand the Firefly Pediatrics Patient Information brochure. I understand the stated policies of this practice and I agree to be bound by their terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ I understand that I and my child have the right to request a chaperone be present during any visit and, when possible, will be of the gender of my or my child's choice. I also understand that a chaperone will be offered for all adolescent (age 12 years and up) genital, rectal, breast, or full body skin examinations.

_____ I have received and reviewed a copy of Firefly Pediatrics' Notice of Privacy Practices, which describes how patient health information may be used and disclosed. I understand that Firefly Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to *Firefly Pediatrics, Privacy Officer, 7693 Rhea County Hwy, Ste 1, Dayton, Tennessee 37321*. The most up-to-date Notice of Privacy Practices is also located on the practice website at www.fireflypediatrics.org. If I have a complaint regarding privacy or other issues, I understand that I may complain to the HIPAA Privacy Officer.

_____ I authorize Firefly Pediatrics, its clinicians, and its employees to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). If I do not sign this consent, Firefly Pediatrics may decline to provide treatment.

_____ I have the right to request that Firefly Pediatrics restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

_____ I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ I authorize Firefly Pediatrics to process my insurance claims and understand they may use a photocopy of my signature for this purpose. I authorize Firefly Pediatrics to release any medical or other information necessary to my insurance carrier. If I am covered by or eligible for TennCare, Firefly Pediatrics may release protected health information to the Bureau of TennCare. I authorize and direct my carrier to issue payment check(s) directly to Firefly Pediatrics. Regardless of my insurance benefits, I understand that I am fully financially responsible for any and all fees incurred, and I agree to pay such fees in full when permitted by my insurance carrier. I agree to pay all collection costs, court costs, and attorney fees incurred to collect my account.

_____ The insurance information I have provided represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose any and all plans to which I subscribe may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

_____ If my address, telephone number, insurance, or legal custody status changes for any reason, I agree to let Firefly Pediatrics know immediately.

Minor children for whom I am legally entitled to make this agreement (list full names):

Parent/guardian's name: _____ Relationship: _____

Signature: _____ Date: _____