Combination CONSENT FORM

(For Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations)

I understand that as part of my healthcare, Lynchburg Pediatrics. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the Practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

With this consent, Lynchburg Pediatrics. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Lynchburg Pediatrics may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

With this consent, Richeson Drive Pediatrics, Inc. may e-mail/text/call to me appointment reminders and patient statements. I have the right to request that Richeson Drive Pediatrics, Inc. 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.

By signing this form, I am consenting to Richeson Drive Pediatrics, Inc. to use and disclose my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Lynchburg Pediatrics. may decline to provide treatment to me.**

RIGHT OF DISMISSAL

I HEREBY ACKNOWLEDGE THAT THE DOCTORS RESERVE THE RIGHT TO AND IN FACT DO ONLY SEE AND TREAT PATIENTS COVERED BY CERTAIN THIRD-PARTY INSURERS AND THAT AT ANY TIME THE DOCTORS MAY DISMISS ME AS A PATIENT WITH 30 DAYS WRITTEN NOTICE.

ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

PHYSICIAN NAME AND ADDRESS: Lynchburg Pediatrics, 301 Gristmill Drive Forest, VA 24551

In consideration of services rendered in the past and to be rendered in the future to the above-named patients and the undersigned agree to be responsible for the full amount of the charges made for the services rendered by the Doctor regardless of any insurance that may exist.

I hereby authorize my insurance company to pay directly to the doctors the surgical and medical expense insurance benefits in which I may entitled and approve the release of necessary information to my insurance company for purposes of submitting a claim against my medical insurance company.

Lynchburg Pediatric Combination CONSENT FORM

	Patient/Child Name	Date of Birth	Social Security Number
1			
2			
3			
4			
5			
6			
7			

SHARED INFORMATION

Parents Authorization

The following individuals are permitted to bring my child to Lynchburg Pediatrics for treatment, prescription pick-up or forms and record pick-up. I understand that these individuals will be required to show identification when they bring my child in or pick up forms, records, or prescriptions.

	NAME:	RELATIONSHIP TO PATIENT	PHONE NUMBER
1	*		
2			
3			
4			
5			
6			

*Emergency Contact

I have been provided a copy, read, and understand the Lynchburg Pediatric financial policy, consent to treat and HIPAA policy.

The Patient/Guardian is responsible for all fees; regardless of insurance coverage and is also required to pay co-pays at the time of service. Self-pay patients are expected to pay in **full** at the time of services unless other payment arrangements have been made with our Billing Office.

Signature_____ Relationship to patient: _____

Printed name_____ Date_____