PEDIATRIC ASSOCIATES OF WESTMORELAND

GREENSBURG · NORTH HUNTINGDON · MOUNT PLEASANT · CONNELLSVILLE · LATROBE

ACKNOWLEDGEMENT OF RECEIPT: PRIVACY PRACTICES/CONSENT TO TREAT

I, _____, the parent/legal guardian of the below named child:

Name of Child: _____ DOB: _____ Sex: _____

Patient Address: _____ City, State, Zip: _____

hereby authorize and consent to the examination and/or treatment of my child during office and facility visits by the physicians and clinical staff of Pediatric Associates of Westmoreland. I acknowledge that I have received the Notice of Privacy Practices for Pediatric Associates of Westmoreland. In addition, I give permission for the following person(s) to bring my child to Pediatric Associates of Westmoreland in my absence and to act in my behalf and authorize medical care and treatment that may be involved in the healthcare of the patient. In the event of emergency or other illness, I understand that the physicians and staff of PAW will deliver any medical care deemed necessary, regardless of the accompanying adult. **For patients who reside with only one parent or guardian/foster care/non-biological caregivers, a current custody agreement must always be on file to ensure proper contacts.**

1. Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

3. Name: _____ Relationship: _____ Phone: _____

4. Name: _____ Relationship: _____ Phone: _____

AUTHORIZATION FOR VACCINES

I, _____, give permission for the following named person(s) to consent to vaccines, or sign a vaccine refusal form, on my behalf, if I am not present for the appointment.
*** If parents/legal guardians are the only ones that are capable of making these decisions, please indicate below by marking '**none**' on the first line. ***

1. Name: _____ Relationship: _____

2. Name: _____ Relationship: _____

3. Name: _____ Relationship: _____

4. Name: _____ Relationship: _____

Parent/Guardian Signature: _____ Date: _____

******* BELOW FOR OFFICE USE ONLY *******

I have offered the above-named patient/representative with the Pediatric Associates of Westmoreland Notice of Privacy Practices and they have: ☐ accepted ☐ refused delivery ☐ patient/representative was asked to sign form and refused.

PAW Representative Signature: _____ Date: _____

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AUTHORIZATION TO BILL INSURANCE

Patient Name: _____ DOB: _____

#1 Primary Insurance Name: _____ ID #: _____

Policy Holder Name: _____ DOB: _____

#2 Secondary Insurance Name: _____ ID #: _____

Policy Holder Name: _____ DOB: _____

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize Pediatric Associates of Westmoreland to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I further understand that excessively overdue accounts may be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that this authorization shall remain valid for (1) year of date signed.

Patient or Parent/Guardian Signature: _____ Date: _____

PATIENT COMMUNICATION PREFERENCES

Our offices use our Electronic Medical Records (EMR) system to notify patients of their upcoming appointments and remind them of routine well visits, etc. Please tell us if you prefer to be notified by *phone call* or by *text*. Our EMR system will attempt to reach Contact #1 first, and then attempt Contact #2 if Contact #1 cannot be reached.

Contact #1 Name: _____ Phone #: _____ ☐ Call ☐ Text

Contact #2 Name: _____ Phone #: _____ ☐ Call ☐ Text