PATIENT AUTHORIZATION SIGNATURES

Your Child(ren)s Name:

Child's Name	Date of Birth	Sex	Social Security Number
Child's Name	Date of Birth	Sex	Social Security Number
Child's Name	Date of Birth	Sex	Social Security Number
Child's Name	Date of Birth	Sex	Social Security Number
Child's Name	Date of Birth	Sex	Social Security Number

Please initial all applicable boxes.

Initial	
	Financial Responsibility I have received a copy of DV Pediatrics Financial Policies Statement. I am aware that a copy is also located in the waiting areas of DV Pediatrics, LLC, and that I can requested another printed copy I understand that insurance coverage is not a guarantee of payment, and I agree that I am ultimately responsible for payment of services rendered at DV Pediatrics. I am responsible for any health insurance co-payments, deductibles and any remaining balances not covered or payable by my insurance company. I understand that DV Pediatrics is not responsible for knowing what services my plan covers and does not cover. I am aware that a copy is also located in the waiting areas of DV Pediatrics, LLC, and that I can request another printed copy.
	Privacy Practices I acknowledge that I have received a copy of the Notice of Privacy Practices (HIPPA) regarding the use and disclosure of my health information. I am aware that a copy is also located in the waiting areas of DV Pediatrics, LLC, and that I can request another printed copy.
	Missed Appointments I acknowledge that I have received a copy of the Missed Appointment Policy. I understand that DV Pediatrics, LLC will attempt to confirm appointments when administratively reasonable to do so. However I acknowledge it is my responsibility to keep up with my appointment times, and to notify DV Pediatrics if I am unable to keep that appointment, or be subject to a $25 per patient per appointment missed appointment charge. I am aware that a copy is also located in the waiting areas of DV Pediatrics, LLC, and that I can request another printed copy.
	Policy on Sick Visit Co-Pays When Added To Well Child Check I acknowledge that I have received a copy of the DV Pediatrics, LLC policy statement regarding Co-pay requirements when a Sick Visit is added to the Well Child Visit. I acknowledge that failure to pay co-pay at the time of service may generate an additional $25 patient responsible charge. I am aware that a copy is also located in the waiting areas of DV Pediatrics, LLC, and that I can request another printed copy.
	Authorization for Release of Information I hereby authorize DV Pediatrics to release necessary information for the following reasons: to other physicians for continuing professional care; to any insurance company or their representatives; or otherwise as allowed by law. I release DV Pediatrics from any liability for the release of information, and IO understand authorization is irrevocable and is not limited in time.
	Release of Data for e-Prescribing I hereby authorize DV Pediatrics, LLC to exchange prescription data with any/all prescription networks to facilitate the care of my child(ren) named above. This will include but not limited to medication history check, prescription eligibility coverage, generic vs. branded drug costs, drug interaction verification. This authorization is not limited in time.

Initial	Authorization for Care/Treatment
	I understand that my child(ren) may require medical treatment when I am not able to be present. In my absence I give the individual(s) listed below my permisiton to authorize any and all medical treatment(s) for my child(ren). **Individual(s) Name** ______________________ **Relationship To Patient** ______________________ ______________________ ______________________ ______________________ ______________________ Furthermore in my absence, I give permission to DV Pediatrics, LLC and its entire staff to examine and provide emergency treatment to the child listed above. In addition, the physicians/clinic has my permission to refer my child's emergent care and treatment to the appropriate service for the treatment of illness or injury. Regardless of authorization, I acknowledge that I am fully responsible for payment of all charges related to my child's care whether or not services are covered by insurance. This authorization is not limited in time.
	Consent To Call With this consent I authorize DV Pediatrics, LLC to call my home, or other location that I specify, and leave messages regarding appointment reminders, insurance items, financial information, or any information pertaining to my child's clinical care, including lab and x-ray results. Please indicate how you prefer to be contacted regarding the following (check one for each item): ***Medical Issues:*** o Home phone o Cell Phone Phone #__________________ ***Appointment Reminders:*** o Home phone o Cell Phone Phone #__________________ ***Appointment Recalls:*** o Home phone o Cell Phone Phone #__________________
	PHI Release Who do you authorize to receive your child(ren)'s Personal Health Information (who in your family do you authorize us to speak with, i.e. ; step-parents, babysitters, grandparents) from DV Pediatrics, LLC. If a person, other than the legal parent/guardian, is not listed below, they will not be able to gain access to your PHI, either written or verbal. **Individual(s) Name** ______________________ **Relationship To Patient** ______________________ ______________________ ______________________ Description of information that may be disclosed: ____ ____ You may revoke or terminate this authorization by submitting a written revocation. You should contact the Privacy Officer to terminate this authorization. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.
	Reserved

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Print Name Parent/Guardian

____ **Date** ______________
Signature of Parent/Guardian