KIDS FIRST PEDIATRICS
growing families one kid at a time

Name and DOB of all KFP patients:

_____

_____

_____

Authorization to Release Billing Information:

I hereby authorize the treating provider to release any information required in the course of my examination or treatment to my insurance company, providers, individuals, and entities authorized by me or their contracted entities. [If the patient is a minor, the parent or legal guardian must sign]

Please note that the use of all daily authorized and released records are not under Kids First Pediatrics, PC control.

AUTHORIZATION FOR PATIENT PICTURE: I authorize Kids First Pediatrics to take a picture for my electronic medical records if I do not produce a current photo ID.

Name of Patient: _____ Date:_____

Signature of Patient/Patient's Representative_____

Assignment of Benefits TO Kids First Pediatrics, PC

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans or other payers, for service rendered by Kids First Pediatrics, and the medical professionals caring for me during my treatment in this office to be paid directly to Kids First Pediatrics, or other associated providers as appropriate. I understand that I am responsible for all charges not paid by insurance. This assignment will remain in effect until revoked in writing by me.

Signature of Patient/Patient's Representative_____

Acknowledgment of Receipt of HIPAA Privacy Practices and Consent

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices.

By signing this form, I hereby acknowledge that I have had the opportunity to read the Notice of Privacy Practices of Kids First and understand that in compliance with that notice, Kids First is allowed to use or disclose my individually identifiable health information for purposes of treatment, payment, and health care operations. I further understand that the Notice of Privacy Practices provides a more complete explanation of the use or disclosure of my individually identifiable health information.

I have been offered a copy of the Kids First Pediatrics HIPAA Notice of Privacy Practices and understand the information it contains.

Signature or Patient/Patient's Representative_____ Date: _____

Form edited 1.2026