carolina developmental pediatrics

Patient Name: _____

CONSENT FOR TREATMENT

I grant permission to the attending physician(s) and professional staff or to their designees at Carolina Developmental Pediatrics, PA (CDP) to render medical treatment or diagnostic procedures including psychological/neurodevelopment, physical and educational assessment as deemed necessary during my child's care. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made regarding the result of treatments or examinations.

RELEASE & ASSIGNMENT OF BENEFITS

I authorize CDP attending physician(s) and professional staff, or their designees to release medical information and billing information including, but not limited to information about my child's diagnosis, care and treatment for financial coverage to any third party or its agents requesting medical and other information for the purpose of determining eligibility for insurance or other public benefits, processing insurance claims or assessing quality, cost and appropriateness of medical care.

I hereby assign to CDP any insurance or other third-party benefits available for health care services provided to me. I understand that CDP has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to CDP, I agree to forward to CDP all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt

HIPAA COMPLIANCE

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. It is the policy of CDP to keep your information private except as stated above, and within the limits of the law. By signing this document I hereby state that I have had the opportunity to review the HIPAA documents and had any questions answered. I understand that this consent shall remain in force from this time forward and that I may revoke my consent at any time in writing.

COMMUNICATIONS

By my signature below, I give consent for CDP to contact me via phone, text or e-mail communications. I understand that CDP will make every effort to balance keeping my medical information private while still communicating needed medical information. I do not hold CDP or staff liable if my information is accessed by parties other than myself.

_____ _____

Signature of Responsible Party Witness

_____ _____

Printed Name of Responsible Party Date

_____

Relationship to Patient