Financial Policy, Assignment of Information, and Release of Information.

I authorize release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company or Medicare of Medicaid on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as a guarantor. I authorize (assign) any insurance or Medicare of Medicaid benefits to be paid directly to Sunrise Pediatrics PLC. Or it's assignees. I am responsible for any non-covered services, supplies, co-payments or deductibles. I am responsible for knowing how my plan works, and I request medical services at this office. I acknowledge that it is my responsibility to inform the practice of any plan changes. If Sunrise Pediatrics does not receive payment for services rendered because of my failure to do so, I will be solely responsible for the balance. This acceptance and assignment will be in force for all future services by practitioners form this office.

_____ _____ _____/_____/_____

Printed name of parent or guardian Signature of parent or guardian Date

Acknowledgement of Receipt of Notice of Privacy Practices

Sunrise Pediatrics is required to provide you with a copy of its Notice of Privacy Practices stating how it may use and/or disclose your health information. This form acknowledges receipt of this notice. The most recent version of this notice is posted in the waiting room area.

I understand that I can request an additional written copy of this Notice at any time. I understand that I have the following rights and privileges:

*The right to review the notice prior to signing this consent, and

*The Right to request restrictions as to how my health information may be used or disclosed.

I have had an opportunity to receive and review the Notice of Privacy of Sunrise Pediatrics PLC.

_____ _____ _____/_____/_____

Printed name of parent or guardian Signature of parent or guardian Date

Consent for Medical Treatment

I hereby give consent for medical treatment of my children who are minors (Please list all children):

_____ _____ _____

_____ _____ _____

I grant my permission for treatment at Sunrise Pediatrics PLC, by a licensed physician, licensed nurse practitioner, licensed physician assistant, and /or designees, including such personnel as the physician may deem necessary. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment.

I am giving permission for the following adults to bring my child for your treatment.

_____ _____

_____ _____

This consent will be in effect from this date until the above minors are 18 years of age unless canceled earlier by me in writing.

_____ _____ _____/_____/_____

Printed name of parent or guardian Signature of parent or guardian Date