Goodlettsville Pediatrics, P.C. (GoodPeds)

200 Gleaves St., Suite A
Madison, TN 37115
(615) 851-7865 / www.goodpeds.com

CONSENTS and AUTHORIZATIONS

To be provided care, I understand that I must sign below to all GoodPeds' policies.

Patient's Full Legal Name_______________________________ **DOB** _______________

Initial _____ **Consent to treatment**: I hereby request and give consent to allow GoodPeds and its staff to administer treatment and perform any such procedures as may be necessary in the diagnosis and/or treatment of myself if over 18, or my child's physical condition. This will include medical and/or minor surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for me or my child's health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Initial _____ **Notice of Privacy Practices:** Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have been given the opportunity to receive a copy of Notice of Privacy Practices.

Initial _____ **Disclosure of Protected Health Care Information (PHI):** I give my consent and authorization for the staff of GoodPeds to leave protected healthcare information about my child or about me on my answering machine or voicemail via the telephone at the number(s) I have listed as my contact information that I have provided on the **Contact Form** provided to me. I understand I may revoke or change this privilege at any time by completing another Contact Form.

Initial _____ **Secured Online Patient Portal with notifications via email:** I give my consent and authorization for the staff of GoodPeds to give me access to PHI about my child or about me on my secured online patient portal account that I must set up with a User ID and Password after giving my email address. I understand that I will have limited access to my or my child's information on this portal and will contact GoodPeds' staff if I have questions or concerns and can disable access at any time by calling GoodPeds and deleting my email address from my account.

Initial _____ **Release of Medical Information and Authorization to pay insurance benefits:** I authorize my physician and his/her agents employed by Goodlettsville Pediatrics to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to Goodlettsville Pediatrics on my behalf.

Initial _____ **Financial/Office Policies:** I have been given a copy of the financial/office policies of GoodPeds and agree to them.

_______________________________________   ____________________

Printed Name of Responsible Party   Specific Relationship to Patient

_______________________________________   ____________________

Signature   Date of Signature