PATIENT NAME

DATE OF BIRTH

PEDIATRIC ASSOCIATES of SPRINGFIELD, INC.
1000 East Primrose, Suite 560
Springfield, MO 65807

AUTHORIZATION, FINANCIAL OBLIGATION and CONSENT

Authorization to Release Information: I authorize the disclosure of any or all information in my medical or accounting record, including information regarding the diagnosis or treatment of HIV, AIDS, mental illness, or substance abuse, to any person, corporation or agency responsible for determining the necessity, appropriateness, payment or other matters related to treatment or services. This includes, but is not limited to, insurance carriers and companies, managed care plans, health maintenance organizations, preferred provider organizations, workers' compensation carriers, welfare agencies, Medicaid and its intermediaries and carriers, or my employer, which may be necessary to process any claim related to these medical visits. I further agree that if my injury is work-related, I authorize the disclosure of my medical record related to my work-related injury to my employer or employer's representative. This also authorizes Pediatric Associates to leave phone messages on my home phone, cell phone and email regarding appointments, medical information and billing issues.

Financial Obligation: I agree that I am financially responsible for payment of all amounts due for services provided by Pediatric Associates. I further understand that I am responsible to pay for such services regardless of whether I have insurance coverage or whether other parties may also be responsible to pay for my care. I will not be responsible to pay for such services rendered if my financial obligation is waived by contractual agreements between Pediatric Associates and my insurer, or if prohibited by applicable state or federal laws or regulations. In the event of collection, I agree that the cost of collection, including reasonable attorney's fees and court costs, will be included as my part of my financial obligation. This agreement shall be governed by Missouri law, and I hereby waive venue and agree that venue shall be appropriate in Greene County.

Notice of Privacy Practices: Pediatric Associates Notice of Privacy Practices sets forth my rights regarding my personal health information and the ways in which it may be used or disclosed. I acknowledge that on _____ (date)
_____ I received a copy of the Pediatric Associates Notice of Privacy Practices.
_____I declined a copy of the Pediatric Associates Notice of Privacy Practices.
The notice of Privacy Practices is available upon request. This privacy practice also authorizes Pediatric Associates to leave phone messages on my home phone, cell phone and email regarding appointments, medical information and billing issues.

Consent for Treatment: I agree, request and authorize Pediatric Associates to provide healthcare services to me and further consent to any examination, tests, immunizations or procedures that may be advisable or necessary for routine diagnostic purposes or to diagnose or treat my medical condition. I am aware that the practice of medicine is not an exact science and understands that no promise, guarantee or warranty has been made regarding the results of the examination or treatment I receive.

I certify that I have read all parts of this Authorization, Financial Obligation and Consent form, accept all its terms and conditions, that all representations made by me are true, and that a copy of this form is effective and valid as the original.

_____ _____

Signature of Patient, Parent (if minor child), or Guardian ***Date***