HIPAA, Consents, and Financial Policy

Onslow Pediatric Associates, P.A. 51 Office Park Drive Jacksonville, NC 28546
PH 910-577-5199 Fax 910-577-3424

Patient Name: _____ **D.O.B.** _____
LAST FIRST MI

Patient Acknowledgement of Receipt of Notice of Privacy Practices: I acknowledged that I have received a copy of Onslow Pediatric Associates, P.A.'s Notice of Privacy or have been notified that a copy can be found on opakidz.org, which provides information about how Onslow Pediatric Associates, P.A. uses and discloses protected health information ("PHI") about me.

Consent To Disclosure of PHI to Family Members, Relatives, Friends or Others: I agree that Onslow Pediatric Associates, P.A. may disclose my PHI to the following family members, relatives, friends or others listed below. I understand that, if I am present, Onslow Pediatric Associates, P.A may disclose my PHI to other family members, relatives or friends if I orally agree or do not object. I also understand that, if I am not present or am incapacitated, Onslow Pediatric Associates, P.A. may make limited disclosure of my PHI to other family members, relatives or friends if determines in its Onslow Pediatric Associates, P.A. professional judgment that such disclosure is in my best interest.

Consent for Treatment: I hereby authorize the performance of any medical treatment which may be advised and recommended by any attending provider at Onslow Pediatric Associates, P. A.. I also authorize the following list of family members, relatives, friends or others to consent, on my behalf, to the performance of any medical treatment recommended by any attending provider at Onslow Pediatric Associates, P. A.. **This includes vaccinations that may be required <u>unless notified by me in writing</u>**.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Financial Agreement: I understand that I am financially responsible to the physicians at Onslow Pediatric Associates, P.A. for services rendered and charges not covered by insurance. I understand that my insurance will be filed as a courtesy to me and allow payment of any filing to be made to Onslow Pediatric Associates, P.A. and its providers. **If I have no insurance to cover services rendered, a $100 deposit for office services is required prior to receiving the service(s). I understand if a scheduled appointment is missed without a 24 hour cancelation notice, a fee of $50 will be charged that insurance will not cover.**

I certify that the information provided is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in completion of this form. This form will expire 1 year from the date signed.

Signature of Patient or Legal Guardian Relation if not Patient Date