SPRING HILL
Pediatric Care

HIPAA PATIENT CONSENT FORM

Our notice of privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a patient right section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operation. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and heath care operation. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already in reliance on your prior consent. The practice provides this to comply with the health insurance portability and accountability act of 1996 (HIPAA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy and that the patient has the opportunity to review this Notice.
- The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may conditions receipt of treatment upon the execution of this consent.

This consent was signed by: _____

Printed name Relationship to Patient

_____

Signature Date

Patient(s) name(s) and dates of birth:_____

_____

_____

INSURANCE RELEASE

I, the undersigned certified that I (or my dependent) have Insurance and assign directly to Spring Hill Pediatric Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurances submissions.

FINANCIAL STATEMENT

Payment is required for all services at the time they are rendered unless you are covered by an insurances plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payments in the form of cash, check, or credit card. In the event of major procedures, your insurances coverage will be pre-verified and you will be asked to pay any unpaid deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, the collections fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

PRIVACY NOTICE ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTOOD THE NOTICE

PATIENT (PARENT/GUARDIAN) SIGNATURE PRINT NAME DATE

Witness: _____