THIS DOCUMENT IS TO BE SIGNED BY A PERSON LEGALLY RESPONSIBLE FOR THE PATIENT'S MEDICAL DECISIONS

Authorization to Treat

I hereby request and authorize Candlewood Valley Pediatrics and its personnel to deliver medical care to the child/children listed below as may be deemed necessary in the diagnosis and treatment of the minor child. Medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, lab work, etc.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that Candlewood Valley Pediatrics (CVP) has provided me with a copy of its Notice of Privacy Practices that describes how medical information may be used and disclosed, and how I can access this information. I understand that I may contact Evan Hack, MD or Annette Martin at 860-355-8190. I also understand that I am entitled to receive updates upon request if CVP amends or changes its Notice of Privacy Practices in any material way.

Release of Information

I hereby authorize CVP to release and disclose to my insurance carrier(s), as applicable, any information for determining benefits or benefits payable for related services and any information necessary for purpose of accreditation, audits, certification, and peer or utilization reviews. I also authorize CVP to release and disclose to any other healthcare provider any information necessary in providing medical services.

Assignment of Benefits

I hereby authorize that any insurance benefits payable for services provided by CVP, as applicable, be paid directly to CVP. I understand that this assignment does not relieve me of any responsibility I may have for payment of any other charges not covered by the insurance carrier(s), as acknowledged below.

Acknowledgement of Financial Responsibilities

There are many rules, regulations and limitations imposed by each different managed care company. I acknowledge that it is my responsibility to provide CVP with accurate and complete insurance information at the times services are rendered and that it is my responsibility to be aware of any limitations on coverage related to my insurance policy. I acknowledge that I am financially responsible for any co-pays and/or coinsurance amounts at the time services are rendered. I also acknowledge that I am financially responsible for all deductibles, non-covered benefits and amounts not paid by insurance as a result of my failure to provide accurate and complete insurance information at the time services are rendered. To the extent that I do not have current insurance coverage at the time services are rendered, I acknowledge that I am responsible for payment in full of such services and that, if payment cannot be made at the time services are rendered, I will make appropriate arrangements with CVP's billing department.

Authorization to View Outside Medication History

I hereby authorize Candlewood Valley Pediatrics to view my/my child's outside medication history.

***** A fee will be charged for any appointment not cancelled 24 hours in advance. These fees are not covered by insurance and will be your responsibility. The fees are as follows: sick appointments- $25 and physical appointments- $50.**

The undersigned patient/responsible party acknowledges receipt of this form, and agrees to the terms set forth herein.

PATIENT's printed name____

Signature of patient or Responsible Party _______________________________

Responsible Party's printed name_____________________________________

Relationship to patient____

Date ______________________

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