Premier Care Pediatrics
16637 Fishhawk Blvd. Suite 101 • Lithia, FL 33547-3800
Phone (813) 657-7337 • Fax (813) 661-4702
http://www.premiercarepeds.com

PARENT'S ACCEPTANCE OF POLICIES

Patient Privacy Practices
By signing here, I am acknowledging that I have received a copy of Premier Care Pediatrics' Patient Privacy Policy. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

_____ _____
Parent or Patient Signature Date

Patients' Bill of Rights
By signing here, I am acknowledging that I have received a copy of Premier Care Pediatrics' Patients' Bill of Rights. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

_____ _____
Parent or Patient Signature Date

Patient Responsibilities
By signing here, I am acknowledging that I have received a copy of Premier Care Pediatrics' Patient Responsibilities. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

_____ _____
Parent or Patient Signature Date

Financial Responsibilities
I understand that I am responsible for payment of this account, and hereby assume and guarantee prompt payment of all expenses occurred. I am also aware that certain services provided may not be covered by my insurance carrier. I understand that Premier Care Pediatrics will make every effort to notify me if services are known to be non-covered, but in the event that services performed are not covered, I will be responsible for payment of these services. I further understand that payment is due at the time of service, including co-payments. I give Premier Care Pediatrics permission to bill my or my child's insurance company on my behalf, and understand that any outstanding balance after my insurance company has paid in full will be my responsibility. If my account becomes past due and has to be turned over to collections, I will be responsible for additional fees to cover agency's fees.

_____ _____
Parent or Patient Signature Date

Consent to Treat
By signing here, I am consenting to treatment of myself or my dependent by the physicians of Premier Care Pediatrics. I understand that my medical information may be viewed or shared amongst the staff of Premier Care Pediatrics and that every effort will be made by Premier Care Pediatrics to protect my health information as is required by HIPAA regulations.

_____ _____
Parent or Patient Signature Date

Permission to Release Medical Information
By signing here, I authorize Premier Care Pediatrics to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, third-payers or their reviewing agencies. This information will be limited to that which is necessary to expedite claim processing. **This authorization is valid for every visit to Premier Care Pediatrics until written notice revoking this authorization is provided by the patient or patient's legal representative.**

_____ _____
Parent or Patient Signature Date

If you are signing for the patient, please indicate your relationship here: _____
Relationship to Patient