

SIGNATURE SHEET

Patient's Name

Date of Birth

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ASSIGNMENT OF BENEFITS

I hereby authorize any physician of Valley Pediatric Associates, LLC, to apply for benefits on my behalf for services rendered. I request and authorize payment from my insurer to be made directly to such physicians. The insurance information I have reported to you is correct and I authorize the release of any necessary information, including medical information for this or any related claim, to my insurance company. A copy of this authorization may be used in place of the original.

CONSENT TO TREAT

I (or my legal guardian or parent) authorize Valley Pediatric Associates, LLC, to provide medical care reasonable by today's standards, including sharing of necessary information with insurance companies and pharmacies to allow e-prescribing.

HIPPA / RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of Valley Pediatric Associates, LLC, Notice of Privacy Practice, which provides information about how we may use and disclose your protected health information.

FINANCIAL POLICY

I have carefully read, understand, and agree to Valley Pediatrics' Financial Policy dated 2021.

FORMS

I have read and agree to Valley Pediatrics' policy on school/camp/ sports forms.

CARD ON FILE

I authorize Valley Pediatric Associates, LLC, to charge my credit card on an ongoing basis for amounts I owe, as outlined in the Financial Policy. I understand I must cancel this authorization through written notice. I agree to contact Valley Pediatrics if there are any changes to my credit card account information. The signature below will serve as the credit card authorization signature.

X _____
Parent / Guarantor

Date

X _____
Parent / Guarantor

Date