SIGNATURE SHEET

__________________________________ ____________________
Patient's Name Date of Birth

__________________________________ ____________________
Patient's Name Date of Birth

__________________________________ ____________________
Patient's Name Date of Birth

__________________________________ ____________________
Patient's Name Date of Birth

Financial Policy

I have read, understand, and agree to the Financial Policy of Valley Pediatric Associates, LLC, dated ____________________, 20________.

X __________________________________ Date: ____________________
Parent / Guarantor

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.

X __________________________________ Date:____________________
Parent / Guarantor

Consent to Treat

I (or my legal guardian or parent) authorizes Valley Pediatric Associates, LLC, to provide medical care reasonable by today's standards.

X __________________________________ Date: ____________________
Parent / Guarantor

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.

X __________________________________ Date: ____________________
Parent / Guarantor