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
Patient's Name	Date of Birth	Patient's Name	Date of Birth
Patient's Name	Date of Birth	Patient's Name	Date of Birth

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 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.

APPOINTMENT POLICY

I have read and agree to Valley Pediatrics' policy on making, keeping & missing appointments.

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 fi 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