INTERLACHEN PEDIATRICS

Consent and Authorizations

Your Signature Will Serve for All of the Following:

Consent: I hereby give consent for Interlachen Pediatrics, P.A. to provide necessary treatments discussed. I have received a copy of the Privacy Policy of Interlachen Pediatrics, P.A. and authorize use/disclosure of information to coordinate and/or manage my child(ren)'s healthcare and any related services, receive payment for services and perform general healthcare operations.

Interlachen Pediatrics, P.A. may contact me at my primary phone number or other alternate phone number I have provided. If I am not available Interlachen Pediatrics, P.A. may leave a message on voice mail in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminders, insurance items and any calls pertaining to clinical care, including laboratory and radiology results among others as per the Privacy Policy.

Interlachen Pediatrics, P.A. may contact me at my mobile phone number or other mobile phone number I have provided by text message to remind me of future appointments or to alert me of documents that need my attention prior to a scheduled appointment.

Interlachen Pediatrics, P.A. may mail to my home, or other alternate address I have provided, any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, school immunization and or physical forms; all correspondence will be marked "Personal and Confidential".

Interlachen Pediatrics, P.A. may e-mail my personal e-mail address, or any other alternate e-mail I have provided, any items that assist the practice in carrying out TPO.

Medical Release: I authorize any holder of medical or other documentation about my child(ren) to release to Interlachen Pediatrics, P.A. , independent laboratories and insurance carriers any information needed for claims processing and payments. I permit a copy of this authorization to be used in place of the original.

Insurance Authorization: I authorize payment of medical benefits directly to the Interlachen Pediatrics and/or the attending physician for services rendered.

Financial Responsibility: I have received a copy of Interlachen Pediatrics, P.A. Financial Policy and agree to abide by the terms set forth. I acknowledge that I am ultimately responsible for all charges incurred by my child(ren). It is my responsibility to provide the office with all necessary information to file insurance claims, and to notify the office of changes in coverage prior to any visits. ***I understand it is my responsibility to know my insurance coverage and benefits, including contracted laboratories/hospitals where my child(ren) may receive care.*** I understand all co-pays, patient percentages and deductibles are due at the time services are rendered**.** I will be responsible for any charges not covered by my insurance policy.

Nondiscrimination Statement: Interlachen Pediatrics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, nation origin, age, disability, sex or sexual orientation.

_____ _____

Signature Date

_____ _____

Print Name/Relationship Child's Name (Please Print)