BIRTH & BEYOND
PEDIATRICS

PATIENT AGREEMENT
AUTHORIZATION FOR MEDICAL TREATMENT

Birth & Beyond Pediatrics, P.C. *(aka BBP)* and its personnel are hereby authorized to administer any medical, diagnostic or therapeutic treatment, including blood transfusions, as may be deemed necessary or advisable. I have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

DISCLOSURE OF INFORMATION

I understand that my child's medical records and billing information are made and retained by BBP and are accessible to office personnel. Office personnel may use and disclose medical information for office operations and functions and to any other physician or health care personnel involved in my child's continuum of care. Safeguards are in place to discourage improper access. BBP and its medical staff are authorized to disclose all or part of my child's medical record to any part of BBP charges and to any health care provider who is or may become involved with my child's care. Oklahoma law requires that BBP advise you of the following: The information authorized for disclosure may include information records which may indicate the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure.

ASSIGNMENT OF INSURANCE BENEFITS

I agree that physician benefits otherwise payable to the insured are to be made payable to the physician(s)/provider(s) responsible for my child's care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits.

PRE-CERTIFICATION POLICY

I understand that BBP will assist with initial insurance pre-certification requirements, but BBP will not assume responsibility for pre-certification or any impact which it may have on insurance payment.

FINANCIAL POLICY

I agree to pay for services rendered by BBP, as stated in the detailed New Patient Financial Policy.

CERTIFICATION

I hereby certify that I have read each of the above statements. I understand or have had each item explained to me to my satisfaction, and have been offered a copy of the Patient Agreement. A photocopy of this document has the same effect as the original.

ACKNOWLEDGMENT OF HIPAA PRIVACY NOTICE

A complete description of how your child's medical information will be used and disclosed by this office is in our HIPAA PRIVACY NOTICE, which you should read before signing this agreement.

I have received a copy of BBP HIPAA Privacy Notice and Patient Agreement. _____

I have been offered a copy of BBP HIPAA Privacy Notice and Patient Agreement and have declined to receive a copy for my personal use. I am aware there is a copy available at my request. _____

A current copy is available at the front desk of Birth & Beyond Pediatrics, P.C.

Patient Name: _____ Date of Birth: ____ /____ /____

Responsible Party: _____ Relationship: _____ Date Signed: ____ /____ /____

Witness: _____