OVIEDO CHILDREN'S HEALTH CENTER

Consent to Treatment & Authorization Form

Patient Name: _____ DOB: _____ / _____ / _____

CONSENT TO TREATMENT: The patient and/or authorized representative of the patient, whose signature is affixed below, does hereby consent to any & all medical treatments & diagnostic examinations administered at or offered in association with the operations of the Oviedo Children's Health Center which treatments/examinations may be deemed advisable by my/the patient's physician to diagnose and/or treat me/the patient during the period I/the patient am accepted as a patient of the Oviedo Children's Health Center.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION: I HEREBY AUTHORIZE Oviedo Children's Health Center to release medical, psychiatric substance abuse information whether contained now or in the future, in my/the patient's records to the following: Insurance carrier(s), employer(s), organization(s), or corporation(s) for the limited purpose of obtaining payment of all or part of the Oviedo Children's Health Center charge for medical care rendered including professional fees of physicians practicing at the clinics, which may include financial & medical record information to substantiate the need for the medical care rendered & the cost associated with medical charges incurred.
The federal HIPPA Privacy Regulations authorize health care providers to share your medical information for treatment purposes without your consent including treatment received after you leave the practice. Florida law, however, restricts (in some instances) the ability of the practice to share your medical information with health care providers for treatment purposes, if treatment is sought after your discharge. By signing this consent, you authorize the release of your medical records (current & historical) to health care providers with whom you or your treating physician(s) may consult for medical treatment. If you do not want to consent, you must cross through this paragraph & place your initials in the margin next to the paragraph.
This consent will remain in force during the period that I/the patient is accepted as a patient of the clinic. You may revoke this authorization at any time by notifying the clinic in writing; however, your revocation will not affect any action taken by the clinic prior to receipt of notice of your revocation and the clinic has a reasonable opportunity to act upon the revocation.
Information disclosed pursuant to your authorization is from records whose confidentially is protected by Federal or State law. Federal regulations or State or as otherwise permitted by Federal/State law.

◯ I grant Oviedo Children's Health Center permission to view my child's medication history prescribed by other medical providers.

ASSIGNMENT OF INSURANCE BENEFITS: I assign payment directly to Oviedo Children's Health Center all insurance benefits otherwise payable to me for medical treatment rendered by the clinic. I understand I am financially responsible for changes not paid by this assignment, and the I/the patient will assist in the collection of my/the patient's insurance should there be any delay in payment. ***If the patient's insurance payment has not been received by Oviedo Children's Health Center within 30 days of billing, I/the patient agrees to actively and vigorously pursue collecting of the insurance payment. If my/the patient's insurance has not remitted charges due within 45 days of receipts of treatment, I understand the entire balance becomes due and that the Oviedo Children's Health center may seek payment direct from me/the patient. This assignment of benefits is irrevocable.*** Return checks are subject to electronic redeposit without further notice. State authorized returned check fees will be assessed and will be debited from your account without further notice, along with the face amount of the returned check.

INSURANCE RECORD OF UNDERSTANDING: Your insurance company may require pre-authorization (precertification), usually through your physician to determine for which service(s) they will pay. Your insurance company may not pay your claim or may reduce your benefits if you do not provide us with a proper authorization. After the pre-authorization is obtained, additional information may be required by your insurance company for each visit to be covered. I understand that if I do not obtain the proper authorization, I will personally be liable to pay any penalty up to the total amount charged for the services received.

PARENT/GUARANTOR AGREEMENT: I/we understand that the Oviedo Children's Health Center are not in the business of extending credit and, therefore, the policy of the office is to require *payment in full at the time treatment is rendered.* If the Oviedo Children's Health Center must use the service of a collection agency or a service to encourage prompt payment, a collection charge may be imposed. We may also choose to provide you with notice that you are being discharged as a patient of our clinic.

NOTICE TO GUARANTOR: Do not sign this contract before you read it or if it contains any blank spaces. You are entitled to an exact copy of this agreement you sign. The undersigned hereby acknowledges receipt of a copy of the above disclosure statement containing all information pertinent to the transaction. By signing this patient/guarantor agreement, the guarantor agree(s) to guarantee payment of all charges incurred by the patient for services at Oviedo Children's Health Center. This is an absolute guaranty and it shall continue as long as my balance is due and owing for medical care rendered by Oviedo Children's Health Center to the patient.

I understand I am financially responsible for my account with Oviedo Children's Health Center regardless of any insurance benefits. By my signature below, I acknowledge reviewing the information contained in this document. ***By signing this form I acknowledge that I have received the HIPAA Notice of Patient Privacy Practices Document at Oviedo Children's Health Center.***

_____ _____/_____/_____
Patient, Parent, Guardian or Other Representative Signature Date

_____ _____
Patient, Parent, Guardian or Other Representative Printed Name Staff Witness Signature