Patient Consent Form

Privacy:

I understand that under federal law, I have certain rights to privacy regarding my child's protected health information. This information will be used primarily in the following ways:

To plan and carry out treatment among the doctors and health care personnel involve in that treatment directly and indirectly.
To obtain payment from third-party payers such as insurance and Medicaid.
To conduct normal practice operations such as quality assessments or physician certifications.

I understand that my health information may also be disclosed at my written authorization for any purpose, for example, to family or friends involved in my health care or payment. Also, CPAC may be required by law to disclose my information to law enforcement or military personnel if necessary to avert a serious threat to my health or safety or the health and safety of others. In the event of my incapacitation or in emergency circumstances, CPAC personnel will use professional judgment to determine whether my information must be shared with another person in my best interest. For my convenience, CPAC may send appointment reminders as voicemail messages, postcards or letters.

I understand that the CPAC *Notice of Privacy Practices* contains a more complete description of the uses of my health information. I have been given a copy to read the *Notice* before signing the consent.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that CPAC is not required to agree to my requested restrictions; however, if CPAC does agree, then CPAC is bound to abide by those restrictions. I understand that I may revoke this consent in writing at any time except to the extent that CPAC personnel have already taken action relying my consent.

Payment:

I understand that I am responsible to pay CPAC for services rendered to my child. *I will provide CPAC with current information about my insurance or Medicaid coverage* and I authorize payment directly to CPAC of any benefits otherwise payable to me. Any refunds due me as a result of overpayment shall be first applied to any other outstanding balance that are my own responsibility. If my insurance policy contract requires me to pay a copayment, deductible or percentage of charges, then I agree to do so when using CPAC services. A deductible is the amount I have to pay on my own before instance even begins to pay; the amount varies from company to company. Coinsurance is a portion I may have to pay toward covered services. CPAC accepts several different insurances and certain services may not be covered by all insurances. I understand that I may ask in advance for pricing information about those services for which I may have to pay. I also understand that *CPAC is not a party to any contract I may have with an insurance company* and therefore CPAC has no control over my coverage. It is my responsibility to find out what my benefits are. I understand that I am responsible for any claims that my insurance company does not pay. If my account remains unpaid after a reasonable amount of time, CPAC may have to use a collection agency to recover the money that I owe. I will give prompt attention to my CPAC statements. If I think my bill is in error, I will contact CPAC to correct it.

Parent/Guarantor Signature: _____ Date: _____

Witness Signature: _____ Date: _____