Acknowledgement and Assignment of Benefits

1. Child Name _____ D.O.B. _____ Male/Female
2. Child Name _____ D.O.B. _____ Male/Female
3. Child Name _____ D.O.B. _____ Male/Female
4. Child Name _____ D.O.B. _____ Male/Female
5. Child Name _____ D.O.B. _____ Male/Female

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided the Notice of Privacy Practices which describes how medical information about my child(ren) may be used and disclosed, and how I can get access to this information. To remain environmentally friendly, I understand that this information is available online at www.chicopediatrics.com and a printed copy will be provided at my request.

Initials_____

FINANCIAL & OFFICE POLICIES

I hereby acknowledge that I have read and I understand Chico Pediatrics financial and office policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Initials_____

ASSIGNMENT OF BENEFITS

I hereby authorize all insurance benefits to be paid directly to Chico Pediatrics. for services rendered. I understand that I am responsible for charges as designated by my insurance company (e.g. deductibles, coinsurance, and co-pays). I am also responsible for charges not covered by insurance and missed appointments fees of $50.00. I authorize Chico Pediatrics to release information to my insurance company when requested.

Initials_____

MEDI-CAL/MEDI-CAL MANAGED CARE PLANS

My child(ren) is not covered by Medi-Cal or any Medi-Cal Managed Care Plan. I understand that should my Child(ren) obtain Medi-Cal or a Medi-Cal Managed Care Plan while being treated at this office, we will no longer be able to continue care at this office

Initials_____

Your signature below signifies that you have read each item, initialed each line, and understand your responsibilities to Chico Pediatrics.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Please Print Name Relationship to Patient