100 NORTH POINTE BLVD.
MOUNT AIRY, NC 27030
Fax 336-786-3796

Patient's Legal Name ____
Last **First** **Middle**
Date of Birth____________________ Sex ( ) F ( ) M Race: ________ *Ethnicity*: ___________SS#________________

Information Regarding Your Child's Parental/Living Status
Mother's Name______________________________ Father's Name____
Step-parent's name (if applicable) ____
Who does the child live with? ____

Email Address____ I decline to give an Email Address _______________

I hereby acknowledge receipt of the, **NO SHOW POLICY, AFTER HOURS POLICY** AND **PATIENTS/PARENTS/GUARDIANS RESPONSIBILITY** given to me by Northern Pediatrics. **I also have been offered a copy of the Notice of Privacy Practice.**

I give permission to Northern Pediatrics to file any claims on behalf of my child to the insurance company for billing purposes of any claims. I understand that I am responsible for any charges in full at time of visit if the child does not have Insurance; or any copays or deductibles not covered by insurance. I further understand that I am responsible for any charges that are NOT a covered service with my insurance plan. I understand that insurance cards presented to Northern Pediatrics, is not a guarantee of payment.

I give NORTHERN PEDIATRICS permission to treat my child and send information to a referral physician if deemed necessary by my physician.

I give the names listed below permission to bring my child, pick up prescriptions, receive treatment information from the doctor and pick up any forms, and sign for immunizations or procedures. **I understand that a child under the age of 18 cannot sign consent.**

Name(s): ____
____

Please initial here for consent

I approve _________ (initials) or refuse ________ (initials)
Northern Pediatrics to fax forms, shot records and discuss general medical information with my child's school, head start or daycare. I understand that I may revoke this authorization at any time by presenting a request for revocation in writing to a Health Information Department of Northern Pediatrics ; however, a revocation will not reverse any action already taken in reliance upon this Authorization.
I also understand that the information disclosed pursuant to the authorization may include information concerning patient's mental health, use or treatment concerning drugs and/or alcohol, HIV/AIDS and/or other communicable diseases and/or genetic testing results.

I understand that I have the right to request restrictions concerning the use of my information. Below are those restrictions:

____

Parent or Guardian Signature___________________________**DATE**:____________________**TIME**:________

011117 – 03/05/2015