GRANDVILLE PEDIATRICS

Patient Authorization

Please read, initial, and sign below.

(Initial)________**Financial Policy**: I acknowledge that I reviewed and agree to comply with the most recent version of the Grandville Pediatrics Financial Policy. April 2018

(Initial)________**Financial Responsibility**: I understand that I am ultimately responsible for payment on my child's/childrens's account. Payment is expected at the time of service. I understand I am responsible to pay my co-pay, co-insurance, or deductible according to my insurance contract at the time of service.

(Initial)________**Insurance Coverage**: I understand that I am responsible to provide Grandville Pediatrics with my current insurance coverage information and insurance card at each card and every visit. I will be responsible for paying any balances due as a result of not providing my most current insurance information. I understand that Grandville Pediatrics may not and/or will not retroactively file claims due to my failure to provide current insurance information.

(Initial)________**Assignment of Benefits**: I hereby authorize payment directly to Grandville Pediatrics, for medical benefits otherwise payable to me. I authorize my insurance company to disclose to Grandville Pediatrics, information regarding my insurance coverage, including, but not limited to verification of my examination and/or treatment to my insurance company and /or other third party payor.

(Initial)_______**No Show Fee**: I acknowledge that I reviewed and agree to comply with the Grandville Pediatrics No Show Policy and agree to pay any fees incurred from failure to comply.

(Initial)_______**Privacy Policy:** I acknowledge that I received, reviewed, and agree to comply with the Grandville Pediatrics Privacy Policy.

(Initial)_______**Immunization Policy:** I understand that Grandville Pediatrics is a Pro-Vaccine office and agree to follow the recommended schedule by the American Academy of Pediatrics.

(Initial)_______**Consent to Treat:** I have the legal right to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that providers of Grandville Pediatrics believe are necessary for my child. I understand that by signing this form, I am giving permission to the doctors, nurses, and other healthcare providers in this medical office to provide treatment to this child as long as my child/children are a patient in this practice.

(Initial)_______**E-Prescribing:** I voluntarily authorize Grandville Pediatrics to allow E-Prescribing for patient's prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history as long as this child is a patient at this office.

(Initial)_______ I understand I am able to withdraw my consent at any time by contacting Grandville Pediatrics in writing at 2845 44th St. SW. Ste#200, Grandville, Mi 49418

Patient Name:____DOB___________________________

Siblings: ____DOB____________________________

____DOB_____________________________

____DOB_____________________________

Parent/Guardian name (print): ____

Parent/Guardian Signature:____

Today's Date:____