



**Caring Pediatrics**  
4439 Rowan Rd.  
New Port Richey, FL 34653  
Phone (727)853-CARE Fax (727)853-2277  
www.caringpediatrics.com

## ACCEPTANCE OF POLICIES

*Patient Name:* \_\_\_\_\_

*DOB:* \_\_\_\_\_

### **Patient Privacy Practices**

By signing below, I am acknowledging that I have received a copy of Caring Pediatrics' Privacy Policy. I understand that it is my responsibility to read, understand and abide by the policy as presented to me.

\_\_\_\_\_  
Legal Guardian or patient signature

\_\_\_\_\_  
Date

### **Patients' Bill of Rights**

By signing below, I am acknowledging that I have received a copy of Caring Pediatrics' Patients' Bill of Rights. I understand that it is my responsibility to read, understand and abide by the policy as presented to me.

\_\_\_\_\_  
Legal Guardian or patient signature

\_\_\_\_\_  
Date

### **Patient Responsibilities**

By signing below, I am acknowledging that I have received a copy of Caring Pediatrics' Patient Responsibilities. I understand that it is my responsibility to read, understand and abide by the policy as presented to me.

\_\_\_\_\_  
Legal Guardian or patient signature

\_\_\_\_\_  
Date

### **Financial Responsibilities**

I understand that I am responsible for payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. I am also aware that certain services may not be covered by my insurance carrier and that Caring Pediatrics will make every effort to inform me of these services. In the event that these services are not covered, I will be solely responsible for payment of these services. I further understand that payment is due at the time of service, and under the law, this includes co payments. I give permission to Caring Pediatrics to bill my insurance company on my (or my child's) behalf, and understand that the outstanding balance, after the insurance company has paid, will be my responsibility. In the event that my account becomes past due, there may be penalty charges and my account can be turned over to collections. I will be responsible for any additional fees and penalties for such service.

\_\_\_\_\_  
Legal Guardian or patient signature

\_\_\_\_\_  
Date

### **Consent to Treat**

By signing here, I am consenting to treatment of myself, or dependent, by Caring Pediatrics. I understand that my/their medical information may be viewed or shared amongst the staff of Caring Pediatrics and its business associates. Every effort will be made to protect my privacy in accordance with the HIPAA regulations.

\_\_\_\_\_  
Legal Guardian or patient signature

\_\_\_\_\_  
Date

### **Permission to Release Medical Information**

By signing here, I authorize Caring Pediatrics to release information from my (or my child's) medical record, to my/their insurance company, third party payers or their reviewing agencies. This information will be limited to that which is necessary to expedite claim processing. This authorization is valid for every visit to Caring Pediatrics until written notice revoking this authorization is provided.

\_\_\_\_\_  
Legal Guardian or patient signature

\_\_\_\_\_  
Date

