RESPONSIBLE PARTY (GUARANTOR)

Responsible party (Guarantor) is the individual who agrees to accept financial responsibility for the payment of all services performed at All Star Pediatrics and Sports Medicine. This individual may not necessarily be the insurance cardholder. Responsible Party must read and sign below.

Name ____
Relationship to Patient____
Address____
E-mail Address: ____
Occupation:____
Social Security Number: ____
Phone (Home): ___________________________ (Cell): _______________________________________
(Other Phone #): ____

I certify that the information I have reported with regards to my insurance coverage is correct. I authorize the release of any medical information necessary to process this claim and I permit a copy of this authorization to be used in place of the original. I also acknowledge that all charges are subject to a service charge of 1.5% per month after 60 days from date of service. Furthermore, I agree to pay any collection costs and legal fees incurred by this office with respect to these charges.

SIGNATURE: ________________________________ DATE: ________________________

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to the PHYSICIAN(S) at ALL STAR PEDIATRICS AND SPORTS MEDICINE for services rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

NAME: ____

SIGNATURE: _______________________________________ DATE: _________________

CHILD ADVOCACY

As advocates for our young patients, All Star Pediatrics and Sports Medicine will not intervene in any custody disputes, or financial responsibility disputes, between parents or other responsible parties. The office will send statements to the address provided. However, we will not look to more than one party to fulfill financial responsibility.

NAME: ____

SIGNATURE: _______________________________________ DATE: ___________________

HIPAA NOTICE OF PRIVACY PRACTICES

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize All Star Pediatrics and Sports Medicine to release any medical or incidental information that may be necessary for either medical care, school forms, or in processing applications for financial benefit.

1) FULL DETAILS OF HIPAA POLICY ON DISPLAY IN OUR WAITING ROOM.

2) Signature below is acknowledgement that you have received this HIPAA Notice of Privacy Practices.

3) A photocopy of these assignments shall be valid as the original.

Patient/Child's Name: ______________________________ Date of Birth:_________________
Parent/Guardian's Name: ____
Parent/Guardian's Signature: ______________________Today's Date:_________________

* Nota de HIPAA de Practicas de Intimidad

La firma debajo es solo reconocimiento que usted ha recibido esta Nota de nuestras Practicas de la Intimidad.

AUTHORIZED INDIVIDUALS

It is the law, and the policy of All Star Pediatrics and Sports Medicine, that you must authorize which family members and other individuals who may make appointments and accompany your child(ren) to their appointments. Therefore, the following individuals (other than parents) are authorized to act in your place with respect to any and all medical matters. Please note that as we have no control over these individuals, any private health information disclosed under this authorization is no longer protected by the Privacy Rule.

1) Name: ______________________________________ DOB:_____________________________
Relationship to patient: ___________________________ Phone#: __________________________
2) Name: ______________________________________ DOB: ____________________________
Relationship to patient: ___________________________ Phone#: __________________________
3) Name: ______________________________________ DOB: ____________________________
Relationship to patient: ___________________________ Phone#: __________________________
4) Name: ______________________________________ DOB: ____________________________
Relationship to patient: ___________________________ Phone#: __________________________
Patient/Child's Name: ______________________________ Date of Birth: ________________
Parent/Guardian's Name: ____
Parent/Guardian's Signature: ________________________ Today's Date: ________________