RAINBOW PEDIATRICS

MUST BE SIGNED BY PARENT OR LEGAL GUARDIAN, OR IF PATIENT IF OVER 18 YRS OLD

PLEASE INTIAL FOR EACH CONSENT

_____I give permission for physicians of Rainbow Pediatrics or persons designated by them, to interview, examine, and perform necessary laboratory/radiological procedures and to provide appropriate treatment to the above named minor. Permission for evaluation and treatment granted whether child presented by parent, other family member, unrelated third party, or unaccompanied.

_____I hereby authorize Rainbow Pediatrics to furnish any necessary information concerning my child named above, to my insurance carriers, to other medical personnel to whom physicians of Rainbow Pediatrics have referred my child for treatment, and to the admitting hospital should my child be admitted for treatment.

_____I understand that all professional charges are charged to the patient. Patients covered under a contracted insurance plan are required to pay any co-payment at the time of service. I understand that **Insurance/Medicaid cards should be presented at EVERY VISIT**.

CONSENT FOR IMMUNIZATIONS

_____I give permission for Rainbow Pediatrics to administer all standard immunizations as recommended by The American Academy of Pediatrics schedule for immunizations. I understand that I will be advised in writing the benefits and risks associated with each immunization at the time of administration.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

_____I have received, or have been given the opportunity to receive, a copy of the HIPAA Notice of Privacy Practices for Rainbow Pediatrics. Copies are available at the front desk.

PLEASE NOTE: This document will remain in effect as long as custody of the child remains the same. In the event of a custodial change or on reaching age 18, a new consent form will need to be signed.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
REQUEST THAT PAYMENT OF AUTHORIZED MEDICAL BENEFITS BE MADE ON MY BEHALF TO RAINBOW PEDIATRICS FOR ANY SERVICES FURNISHED TO ME, INCLUDING PHYSICIAN SEVICES. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE CARRIER OR ITS INTERMEDIATRIES ANY INFORMATION FOR THISOR RELATED CLAIM.

_____ _____

Signature (Patient or Legal Guardian) **Date**

_____

Printed Name (Patient or Legal Guardian)