**Mercer Island Pediatrics**

**Notice of Privacy Practices – Acknowledgement**

We keep record of the healthcare services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless the law authorizes or compels us to do so. You may see your record or get more information about it by contracting Mercer Island Pediatrics.

If you request our providers to compete a form for school, sports, camp, etc., you are giving us consent to provide medical information.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information. This form will be retained in the patient’s medical record.

**Patient Agreement**

**Assignment of Insurance Benefits** hereby authorize Mercer Island Pediatrics to request and directly collect, on my behalf, all public and private insurance coverage benefits due for products and services provided by Mercer Island Pediatrics. If insurance benefits are paid directly to me, I will endorse these checks for such payments to Mercer Island Pediatrics.

**Medical Consent** to all routine, usual, and customary patient tests, procedures, and exams performed or prescribed by the physicians of Mercer Island Pediatrics.

**Release of Medical Information** authorize Mercer Island Pediatrics to release any healthcare information necessary to facilitate the processing of insurance claims and audits of payments relative to the services provided to patient by Mercer Island Pediatrics.

A special Consent for Release of Confidential Information must be signed for those patients’ receiving services related to HIV/AIDS. Mercer Island Pediatrics will keep a record of the healthcare services provided to patient. I may see that record and copy it. Mercer Island Pediatrics will not disclose my record to others unless I direct Mercer Island Pediatrics to do so, or unless the law authorizes them to do so.

**THE PATIENT/GUARANTOR AGREES THAT HE/SHE IS HEREBY FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED FOR SERVICES PROVIDED INCLUDING THOSE THAT MY NOT BE COVERED BY YOUR INSURANCE. THESE MAY INCLUDE FEES FOR MEDICAL SUPPLIES, AFTER-HOURS AND EMERGENCY OFFICE VISITS, HOME VISITS AND AFTER-HOURS PHONE CALL CHARGES.**

A duplicate copy of this Patient Agreement shall be considered the same as the Original.

 **I acknowledge receipt of this notice**

Patient’s Name Printed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_