Village Pointe Pediatrics, P.C. / Dundee Pediatrics

ADULT PATIENT

Consent to Treat / Billing Authorization/ Release of Protected Health Information

Section A - Individual Authorizing Billing/PHI Release

PATIENT NAME: Last: ______________________________ First ______________________________ M.I. _____ DOB:_____/_____/_____

Your Address:____ City: __________________ State: _______ Zip _____________

Cell Phone:_______/_______/_________ Home Phone: _______/______/_______ Email________________________________@________

PRIMARY INSURANCE ________________________ Last Name: _________________ First :__________________ DOB:___/___/____ (for insurance filing)

Address: Street______________________________ City/St/Zip____ (for insurance filing)

Pediatrician: __ K. Anderson__ J. Andresen__ Belin__ Byrne___ Christner___Coffey__Cohen__Davey__Dek__ Larson__ Steinauer

Section B – I authorize my billing statements be sent to: (if you do not list someone, we will bill you.)

Name of Person to Receive Billing Statement	Address Street / City/ State / Zip
1.	

Initial: __________ I understand that I am considered an adult in the State of Nebraska and my billing and medical information is protected by HIPPA. I give my consent to Village Pointe Pediatrics or Dundee Pediatrics to send my billing statements to someone other than myself.

SECTION C - Description of Authorization to Release PHI – This section authorizes the release of your PHI to another person or entity.

Initial: __________ I, the above named patient, authorize Village Pointe Pediatrics (VPP) or Dundee Pediatrics to release my Protected Health Information (PHI). PHI is information about myself that may identify and relate to my past, present or future physical or mental health or condition and related health services.

Initial: __________ I hereby authorize VPP or Dundee Pediatrics to release my PHI as described in this authorization. I understand that my PHI may include, but not limited to, the following: medical records, emergency care records, billing statements, Explanation of Benefits, diagnostic imaging reports, transcribed hospital records, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization.

Initial: __________ I further understand that my PHI may include information related to any of the following: genetic testing, mental health (excluding psychotherapy notes), HIV/AIDS, prescription medication, pregnancy/maternity, organ transplants, and chemical dependency (including alcohol and drug treatment).

Initial: __________ *I further understand that this authorization applies to ALL PHI, except for the following limitation (in none, please leave blank):____

SECTION C -Persons/Organizations Authorized to Receive My PHI

Name of Person to Receive PHI	Relationship To You	Address Street / City/ State / Zip	Start Date	End Date
1.				
2.				

SECTION D - Terms and Conditions of Authorization

I understand that I may refuse to sign this authorization. I understand that VPP may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I also understand that if the person(s) / organization(s) authorized to receive my PHI is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I further understand that I may revoke this authorization in writing at any time.

SECTION E -Financial Responsibility:

I am aware that I am responsible for any outstanding balance whether or not paid by my insurance. I authorize payment of insurance benefits directly to Village Pointe Pediatrics, P.C or Dundee Pediatrics. I understand that it is my responsibility to know my insurance benefits and coverage.

HIPAA: I acknowledge receipt of Notice of Privacy Practices as set forth by the Health Information Portability and Accountability Act (HIPAA) at this visit and at any future visits. I authorize Village Pointe Pediatrics or Dundee Pediatrics to release any of my medical or personal information for evaluation, treatment, consulting, and processing of insurance benefits.

Authorization to Mail, Call or E-mail: I authorize Village Pointe Pediatrics or Dundee Pediatrics representative to leave messages on my voicemail, answering machine and e-mail with communication, including but not limited to appointment reminders, referral arrangements, and balance notices.

Consent to Treat: I, the above patient, give Village Pointe Pediatrics or Dundee Pediatrics consent to administer care/treatment for any present/future treatments from the pediatricians and other health care providers employed by Village Pointe Pediatric, P.C. or Dundee Pediatrics.

Signature: ____ Date: ______/______/________