

HIPAA PATIENT ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your NOTICE OF PRIVACY PRACTICES, which contains a more complete description of the uses and disclosures of my health information.

I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing this consent.

I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization or refer to www.reispediatrics.com at any time to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this acknowledgment in writing at any time, except to the extent that you have taken action relying on this acknowledgement.

MEDICAL TREATMENT AUTHORIZATION

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in any information or the medical status of the minor child referred to on the signed agreement form. I authorize Reis Pediatrics to perform any and all forms of treatment, medication, and therapy with my informed consent in connection with the patient's diagnosis and treatment plan. I also authorize Reis Pediatrics to perform or order any diagnostic procedure(s) and/or test(s) deemed appropriate to make a thorough diagnosis. I authorize Reis Pediatrics to administer such treatment, as they may deem necessary for the patient's diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

Permission to Treat a Minor (Under age 18): In the event of an emergency and I cannot be contacted, I give my permission to Reis Pediatrics to treat my child in their office or appropriate treatment facility as required by the events of that emergency situation.

INSURANCE AUTHORIZATION

Assignment of Insurance Benefits: I hereby authorize payment of medical benefits directly to Reis Pediatrics. I further authorize the release of any medical information necessary for processing the insurance claim and any referral necessary for the care of the patient. I permit a copy of this authorization to be as valid as the original. I understand that all costs not paid by the insurance will become my responsibility unless otherwise prohibited by state or federal regulations. **I understand that if I do not inform Reis Pediatrics of changes in my insurance coverage within 30 days from the date of service that I may be responsible for any charges incurred due to a delay in timely submission of charges.**

MEDICARE LIFETIME AUTHORIZATION

If the patient is covered by Medicare/Medicaid, I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about the minor child named herein above to release to the Social Security Administration, its agencies, intermediaries, or carriers, any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on the patient's behalf I assign the benefit payable for physician services to Reis Pediatrics or the organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I also authorize Reis Pediatrics or the organization to appeal any denial of benefits on the patient's behalf.

PATIENT AUTHORIZATION CONSENT

Patient name: (list all children)

Date(s) of birth:

I, _____, the parent/guardian of the above patient(s) have read and understand the following documents that were given to me to review. I understand that these documents can be found on Reis Pediatrics website.

1. HIPPA Patient Acknowledgement
2. Medical Treatment Authorization
3. Insurance Authorization
4. Medicare Lifetime Authorization

Name of parent / legal guardian

Signature

Date

As required by the Affordable Care Act, we have been asked to collect the following information for the federal government:.

Please circle one answer from each question:

- | | | | |
|------------------------|-----------------------------------|---|---------------------------|
| 1. Ethnicity: | Hispanic/Latino | Non Hispanic/Latino | Refuse to Report |
| 2. Race: | American Indian or Native Alaskan | Asian | Black or African American |
| | White | Native Hawaiian or Other Pacific Islander | Refuse to Report |
| | More than one race | | |
| 3. Preferred Language: | English | If other please specify _____ | |

