WHOLE CHILD Pediatrics

NOTICE OF ACKNOWLEDGEMENT/ASSIGNMENT OF BENEFITS

Patient Name _____ Date of Birth _____

The above-named patient acknowledges receipt of Whole Child Pediatrics/Whole Family Integrative Health Policy and Procedure Form, Financial Policy Form and Notice of Privacy Practices.

The above-named patient understands that the practice reserves the right to change the privacy practices that are described in the notice. The patient also understands that a copy of any Revised Notice will be provided or made available to the patient upon request. The patient is also aware they can receive a copy of said policies by asking the front desk or visiting the website www.wholechildonline.com.

If the patient is a minor, the parent/guardian signing the form acknowledges they are the lawful guardian of the minor listed above and there are no court orders now in effect that would prohibit them from conferring the power to the consent upon another person. They also acknowledge that should this change they have the obligation to notify Whole Child Pediatrics/Whole Family Integrative Health.

Authorization to Release Information

I hereby authorize Whole Child/Whole Family to: (1) release any information necessary to insurance carriers regarding my or my dependent's illness (s) and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from Whole Child/Whole Family on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Assignment of Benefits

By signing this form, I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I authorize and direct my insurance carriers including private insurance, and/or any other health/medical plan to issue payment(s) directly to Whole Child Pediatrics/Whole Family Integrative Health for services rendered to myself and/or my dependents, regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by my insurance. I also authorize the Provider to release any information required to process claims to my insurance carrier including private insurance, and/or any other health/medical plan. Further, I agree that if this results in a credit balance, the credit amount will be applied to any outstanding accounts of mine or a family member.

Signature _____

Relationship to Patient _____ Date _____