PRIVACY & BILLING PROCEDURES

Authorization and Acknowledgement

These authorizations/acknowledgements cover all services rendered to me, or the patient I am signing for, today and all future dates of service. I understand I may revoke this authorization by informing PedPost in writing, but if I do revoke this authorization, it will not affect anything prior to the date the revocation is received by PedPost.

_____

Acknowledgement of Receipt of Notice of Privacy Practices Authorization to Release Information to Family/Friends or Others

I have received a copy of PedPost's Notice of Privacy Practices. I authorize PedPost to release any information regarding my treatment; including lab results, x-rays, and medical records, to the following individuals/entities (PedPost may not release information or records to the names individuals/entities unless you identify them here):

Name & Relationship to Patient_____

Name & Relationship to Patient _____

Name & Relationship to Patient _____

PedPost will use my home phone number and primary address supplied during registration to contact me regarding my treatment; including lab results, x-rays, and medical records. I will ensure this information is up to date at every visit. _____

Authorization to Treat and Bill

I consent to be treated by PedPost. If I am not the patient being treated, I am authorized to consent to treatment and billing for the patient identified below. I authorize PedPost to bill my medical insurance, Employers or Workers Compensation Insurance for the care I receive and to release any information the insurance carrier requires to process this bill. I authorize payment of medical benefits to PedPost, or to outside labs as described below, for all services performed and billed by PedPost. I understand that I am responsible for all charges for the treatment I receive at PedPost. I understand that PedPost providers may utilize the Prescription Monitoring Program service at no additional charge to me._____

As a courtesy, PedPost will bill my medical insurance. If I do not provide complete and accurate insurance information to PedPost, I understand PedPost may not receive payment from my medical or workers compensation insurance company or employer and I will be entirely responsible for my bill. Even after my employer, medical or workers compensation insurance company pays PedPost's bill, I may owe PedPost payment for services not covered by my insurance and I agree to pay these promptly to PedPost. I understand that PedPost may send lab specimens to an outside laboratory. I authorize any lab performing services for me to bill my employer, medical or workers compensation insurance directly or

indirectly for their services. I understand that my employer, medical or workers compensation insurance may not pay for all services provided by the lab and I agree to pay any remaining balance promptly to any outside lab providing services to me. I understand that PedPost is not responsible for payment to outside labs for tests provided to me.

To protect my privacy and prevent fraud, I understand that if I cannot provide acceptable photo identification at the time of service, PedPost may choose not to bill insurance and may decline credit/debit cards and checks as a form of payment. I understand that if I fail to pay PedPost for services provided to me, the balance owed may be sent to collection and I may incur collection fees of up to 25% in addition to the amount owed for services/treatment rendered. I understand that I may contact PedPost to work out payment arrangements that may prevent this additional cost.

Signature_____ Today's Date _____

Patient Name _____ Patient's Date of Birth _____

Name of Patient Representative *_____

Relationship to Patient* _____

*(Required if the patient is a minor or if the patient is unable to sign this form).

For questions about this website privacy policy, contact:

Info@pedpost.com

Phone: (470)-222-0375