Frederick Pediatric Associates

Privacy Notice

Assignment of Benefits/ Financial Agreement

I certify that the registration information I provided is true and accurate. I authorize payment of health insurance benefits directly to FPA, not to exceed balance due of FPA's customary charges for services rendered. I understand the following: Payment is due upon receipt of services. I am responsible for all fees and charges deemed my responsibility according to FPA and my health plan. If I do not provide a VALID insurance card before services are rendered, I will be held financially responsible for all services. I agree that I will pay any outstanding amounts in accordance with FPA's rates and terms. Should the account be referred to an agency for collection, I will pay reasonable fees and collection expenses. It is my responsibility to determine which outside facilities participate with my insurance plan and which services require authorization and errors therein will result in denial of payment by insurance and my responsibility of fees. It is FPA's policy that prescription refill requests are processed only with proper follow up visits and during business hours. I am the patient or person authorized to act on behalf of patient and agreed to terms herein:

Patient's Name: _____ Date: _____
Patient's Signature or
Parent/ Guardian if under 18: _____ Relationship: _____

Acknowledgement of Receipt of Privacy Notice

I, patient (or parent/ guardian) of Frederick Pediatric Associates, have been given a copy of the Privacy Policy. I understand my rights according to this policy and that HIPAA law grants Frederick Pediatric Associates authorization to use and disclose my medical records for treatment/ care and payment operations.

Signature of Patient or Parent/ Guardian: _____ Date: _____

Communication Authorization

FPA providers may contact me at home/ work phone numbers or at my home address regarding my diagnosis, results, treatment and care, or payment. I may request any other means of communication (such as cell phone or mail to different address) or I may deny particular means of communication in writing.
YES, you may call my cell phone at _____. I understand cell phones are NOT considered a private/ secure method of communication.
NO, please do not contact me by the following means: _____

I understand that I may authorize FPA providers to share medical/ billing information about my care/ child's care to relatives, caretakers, close friends, etc and shall list them below:

Name	Relationship	Phone Number

Communication authorization shall be expired under any circumstances as listed below:

1. Upon written request for records release for reason of transfer of care.
2. Upon written request by patient, parent, or guardian.
3. In the case of a minor having reached the age of majority.

Print Patient's Name: _____ Home Phone: _____
Patient/ Guardian Signature: _____ Witness/ Date: _____