happy kids *pediatrics*

Consent Form English

Consent to Obtain External Prescription History

I, (INT)__________________, whose signature appears below, authorize Happy Kids Pediatrics and Its Affiliated Providers to view my child's external prescription history via the ePrescribing service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

Consent to Pay Benefits to Physician

I, (INT)___________________, whose signature appears below, authorize direct payment to be made to the above named corporation. I understand Happy Kids Pediatrics P.C. will file an insurance claim on my behalf as a courtesy; nevertheless, I am financially responsible for the charges not covered by my insurance company. I also understand that if my account is not paid by myself or the insurance company after 90 days from the date of service, it will be turned over to an independent collection agency and a $25.00 fee will be added to the account for processing charges. There will be a $25.00 service charge for any returned check. I hereby certify that I do not have other insurance at this time.

Consent to Release Information

I, (INT)___________________, whose signature appears below, authorize Happy Kids Pediatrics P.C. to release any information required in the course of the patient's examination or treatment to insurance companies for payment. I hereby authorize any photocopies of this form to be valid as the original.

Consent to Release Information to ASIIS

I, (INT)__________________, whose signature appears below, authorize Happy Kids Pediatrics P.C to release information about all vaccinations given to me, or to the person for whom I am authorized to consent, to the Arizona State Immunization Information System (ASIIS), other health care providers and schools in order to avoid receiving unnecessary vaccinations and to provide information about what immunizations have been received. I understand that I am not required to agree to the release of this information in order to receive the vaccinations I request.

Acknowledgement of Receipt of Privacy Practices

I, (INT) __________________, whose signature appears below, acknowledge that I have received a copy of HAPPY KIDS PEDIATRICS "Notice of Privacy Practices." This notice describes how HAPPY KIDS PEDIATRICS may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected information.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

Patient
Name ____________________________________DOB_________________

Parent / Guardian Name (printed)___________________________________

Parent / Guardian Signature :________________________Date:___________