Moon Valley Pediatrics

14001 N 7th Street . Suite G-114 . Phoenix, AZ 85022
Phone: 602-298-6930 Fax: 602-298-6918

(**List names & DOB of all Children**)

Patient Name: _____ Date: _____

DOB: _____

Financial Policy, Assignment Information, and Release of Information

I authorize the release of any information acquired during the course of treatment necessary to complete and file medical claims to my insurance company or Medicare or Medicaid on my behalf. I hereby acknowledge financial responsibility for costs of services rendered for me or for the person whose account I am acting as guarantor. I authorize (assign) any insurance or Medicare or Medicaid benefits to be paid directly to Moon Valley Pediatrics or its assignees. I am responsible for any non-covered services, supplies, co-payments, coinsurance, or deductibles. I am responsible for knowing how my plan works, and I request medical services at this office. This acceptance and assignment will be in force for all future services by practitioners from this office.

Acknowledgement of Receipt of Notice of Privacy Practices

The most recent version of Moon Valley Pediatrics' Notice of Privacy Practices is posted in the waiting room area. I understand that I have the right to review the notice prior to signing this consent and the right to request restrictions as to how my health information may be used or disclosed. This form acknowledges receipt of Moon Valley Pediatrics' Notice of Privacy Practices. Furthermore, I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt-Out Form to my healthcare provider. I understand that I can request an additional written copy of this Notice(s) at any time.

Consent for Medical Treatment

I authorize treatment for my child(ren) at Moon Valley Pediatrics, by a licensed physician, licensed nurse practitioner, licensed physician assistant, and/or designees, including such personnel as the physician may deem necessary. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment. This consent will be in effect from this date until the above minors are 18 years of age unless cancelled earlier by me in writing. I hereby give consent for medical treatment of my children who are minors.

- **I authorize medical information, including lab and other results, to be left on voicemail at:**

Phone # 1:_____ Phone # 2:_____ Phone # 3:_____

- **The following ADULTS are authorized to bring my child(ren) in for treatment:**

Name: _____ Name: _____

Name: _____ Name: _____

By signing below, I consent to all the above.

_____ _____ _____

Printed Name of Parent/Guardian **Signature** of Parent/Guardian **Date**