Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for Treatment:**

I authorize Pediatric Group Associates (PGA) to provide treatment to myself or for the above named patient.

**Assignment of Benefits:**

I authorize my insurance company to pay and hereby assign directly to PGA, all benefits, if any, otherwise payable to me for services. This authorization may be revoked by either me or my insurance company at any time in writing.

**Reference Laboratory Services:**

I understand that PGA utilizes the service of an outside lab to perform some of the lab tests requested by our physicians. I further understand that the Reference Laboratory will bill me separately for its services. I authorize PGA to provide my demographic information as necessary for billing purposes.

**Cancellation of Appointments:**

I understand that I must give at least one hour notice to cancel my appointment. I further understand that future services may be denied if I fail to keep my scheduled appointments.

**Authorization for Release of Medical Information:**

I authorize release of copies pertinent medical records to providers outside of PGA who are being consulted with and/or I am being referred to in connection with my current treatment, to insurance companies for the purpose of determining benefits for services provided, and to reference laboratories for billing purposes.

**Payment Agreement/Collection Policy:**

I, the undersigned, do hereby guarantee payment of all charges for medical services rendered, or to be rendered by PGA. I understand that it is my responsibility to provide PGA with my current insurance information. I understand that a finance charge may be assessed on outstanding balances greater than 90 days old. I agree to be responsible for the balance due on my account plus any costs that are incurred by PGA in the collection of my account.

**Non Violence Policy:**

I understand that PGA is committed to providing its employees and patients with a safe environment and reserve the right to determine whether particular conduct violates this policy or is otherwise inappropriate. Overtly abusive language, verbal and/or threats of physical violence from a patient or patient’s family will not be tolerated and will result in immediate dismissal from the practice.

**Immunization Policy:**

All PGA providers believe that immunizations are very important to your child’s health and are an integral part of maintaining your child’s health. If you choose to not vaccinate your child, we will recommend that you select an alternate practice that will better suit your philosophy and needs. We are happy to discuss any questions or concerns you may have regarding your child’s immunizations and American Academy of Pediatrics’/CDC recommended schedule.  
**PGA participates in I-CARE, the Illinois Immunization Exchange. This allows your child’s immunization history to be accessed by participating medical practices throughout the state. Please initial here to authorize PGA to share your child’s immunization history with I-CARE\_\_\_\_\_\_\_\_\_\_.**

**Forms:**

School, camp, and sports forms will be completed at no charge for your child at his/her scheduled well care appointment. Forms requested at any other time will incur a $10.00 fee.

By signing this form, I am consenting to treatment by PGA and agreeing to these policies. I understand this authorization will remain in effect until I revoke it in writing.

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Date Signature Patient (if 18 yr)/Parent/Legal Guardian Relationship to Patient