Patient Authorization

Please read and sign below.

Financial Policy: I acknowledge that I received, reviewed, and agree to comply with the most recent version of the Liberty Pediatrics Financial Policy dated October 1, 2018.

Financial Responsibility: I understand that I am ultimately responsible for payment on my child's/children's account. Payment is expected at the time of service. I understand I am responsible to pay my co-pay, co-insurance, or deductible according to my insurance contract at the time of service.

Insurance Coverage: I understand that I am responsible to provide Liberty Pediatrics with my current insurance coverage information and insurance card at each and every visit. I will be responsible for paying any balances due as a result of not providing my most current insurance information. I understand that Liberty Pediatrics will not retroactively file claims due to my failure to provide current insurance information.

Assignment of Benefits: I hereby authorize payment directly to LIBERTY PEDIATRICS, for medical benefits otherwise payable to me. I authorize my insurance company to disclose to LIBERTY PEDIATRICS, information regarding my insurance coverage, including, but not limited to verification of my examination and/or treatment to my insurance company and/or other third party payor.

Fee for Forms: I understand that I received notice about the fee for all forms to be completed by Liberty Pediatrics and I agree to pay prior to form completion.

Privacy Policy: I acknowledge that I received, reviewed, and agree to comply with the Liberty Pediatrics Privacy Policy.

Immunization Policy: I acknowledge that I received, reviewed, and agree to comply with the Liberty Pediatrics Immunization Policy.

Consent to Treat: I have the legal right to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that providers of Liberty Pediatrics believe are necessary for my child. I understand that by signing this form, I am giving permission to the doctors, nurses, and other healthcare providers in this medical office to provide treatment to this child as long as my child/children are a patient in this practice.

E-Prescribing: I voluntarily authorize Liberty Pediatrics to allow E-Prescribing for patient's prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history as long as this child is a patient at this office.

Prescription: I authorize Liberty Pediatrics to access my child's prescription history database which allows Liberty Pediatrics to review prescription history.

I understand I am able to withdraw my consent at any time by contacting Liberty Pediatrics in writing at 3735 Corporate Woods Drive #105, Vestavia Hills, AL 35242.

Patient Name: _____DOB: _____

Parent/Guardian name (Print): _____

Parent/Guardian Signature: _____

Today's Date:_____