wasatch pediatrics

ACKNOWLEDGEMENTS AND AUTHORIZATIONS

Account # _____

Patient Name: _____Date of Birth: _____

Phone #: _____

Wasatch Pediatrics is dedicated to providing comprehensive primary care, including behavioral health services. Because wellness involves both the body and mind, our multidisciplinary team of providers work together to offer you superior pediatric care. In order to provide you with coordinated care, your providers may involve other healthcare specialists as part of your care team. Remember, your child's primary doctor, your child, and you are still the leaders of your child's team. Our main job is to help develop and implement the most supportive healthcare plan for YOUR CHILD and family!

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have been offered a copy of the Wasatch Pediatrics Notice of Privacy Practices to read and/or review. I have been given the opportunity to read this Notice and ask questions. Wasatch Pediatrics will make available for me a copy of the current Notice upon my request. The current version will also be available at www.wasatchpeds.net. I understand that this Notice may be revised from time to time without notice and that I am entitled to receive a copy upon my request.

Initials _____

PROCEDURE POLICY

It is possible that your insurance plan may require a copay, deductible and/or the following services may not be covered. If you have questions regarding this, please contact your insurance prior to having the service performed. This list is not all-inclusive or exhaustive. It is your responsibility to know your policy and coverage.

Wart Treatment/Removal Laceration Foreign Body Spirometry Immunizations MChat
Ear Wax Removal Circumcision Drug Testing Burn Care Fracture Care Behavioral Health

Initials _____

CANCELLATION POLICY

Appointments that are not cancelled 24 hours in advance will be charged a fee of up to $100. This fee is your PERSONAL responsibility and not that of your insurance company. The Cancellation Policy also applies to appointments that have been made and then cancelled the same day.

Initials _____

AUTHORIZATION TO PROVIDE CONSENT AND RECEIVE INFORMATION

I authorize the following individuals (other than a parent or legal guardian) to provide consent for treatment for the above-named patient in my absence. These individuals may also have access to medical or financial information regarding the above-named patient. If patient is over 18 years, parents must be listed to receive information.

Name: _____ Phone #: _____ DOB: _____

Name: _____ Phone #: _____ DOB: _____

Initials _____

TWO WAY COMMUNICATION

I authorize the use and disclosure of the above-named individual's health information between Wasatch Pediatrics and the following provider(s). This is used for non-medical providers such as a psychologist or other mental health provider.

Provider Name: _____ Provider Name: _____

Unless otherwise revoked, this two-way communication authorization will expire on: ___ /___ /___

This authorization includes the entire medical record, including coordination of care (or case consultation) except for the following restrictions and/or exclusions:

_____

_____

Initials _____

_____ _____

Parent/Guardian Signature Date

_____ _____

Printed Name Wasatch Pediatrics Employee