

La Altura Pediatrics

Assignment of Benefits

In the event that services rendered are not paid for by the responsible party, I hereby authorize payment of Insurance benefits to La Altura Pediatrics and any assisting providers for services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Parent or Legal Guardian Signature

Date

Consent for Treatment

I, the undersigned, do hereby agree and give my consent for La Altura Pediatrics to furnish medical care and treatment to my child:_____.

I give permission for the following people to bring my child to the office:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Parent or Legal Guardian Signature

Date

Notice of Privacy Practices

I, the undersigned, do hereby confirm that I have been given access to and have reviewed a copy of La Altura Pediatrics HIPPA Notice of Privacy Practices.

Parent or Legal Guardian Signature

Date