AUTHORIZATION AND RELEASE

PATIENT NAME_____DOB_____

1. I authorize Loudon Pediatric Clinic, PC to treat the named patient.
2. I understand that providing incorrect information can be dangerous to my child's health.
3. It is also my responsibility to inform the office of any changes in my child's medical status.
4. I authorize the providers to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such medical care to third party payers and/or health practitioners.
5. I authorize and request my insurance company to pay directly to the physicians.
6. I understand that my medical insurance carrier(s) may pay less or none of the actual bill for services.
7. I agree to be responsible for payment of all services rendered on my behalf for my dependents.
8. I also authorize the medical staff to perform the necessary medical services (such as vision, OAE, hemoglobin, urine, etc.) and vaccines/injectables my child may need and agree to pay any of these charges not covered by my insurance company.
9. I agree to be responsible for any charges my insurance does not cover due to my failure to provide Loudon Pediatric Clinic, PC current and accurate information in a timely manner.
10. If there is no insurance coverage or proof of coverage, I agree to pay the full amount at the time of service unless prior arrangements are made.
11. I certify that I have read and understand the above information to the best of my knowledge.

I UNDERSTAND THAT, IF I HAVE MISSED 3 OR MORE APPOINTMENTS WITHOUT NOTIFICATION TO THE PRACTICE, I WILL BE DISMISSED

Signature of Parent or Guardian **Date**