Premier Pediatrics of Louisiana
325 W. 8th Street • DeRidder, LA 70634
Phone (337) 221-3075 • Fax (337) 221-3076
www.premierpediatricsla.net

PARENT'S ACCEPTANCE OF POLICIES

Patient Privacy Practices
By signing here, I am acknowledging that I have received a copy of Premier Pediatrics of Louisiana' Patient Privacy Policy. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

________ **INITIALS**

Patients' Bill of Rights
By signing here, I am acknowledging that I have received a copy of Premier Pediatrics of Louisiana' Patients' Bill of Rights. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

________ **INITIALS**

Patient Responsibilities
By signing here, I am acknowledging that I have received a copy of Premier Pediatrics of Louisiana' Patient Responsibilities. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

________ **INITIALS**

Financial Responsibilities
I understand that I am responsible for payment of this account, and hereby assume and guarantee prompt payment of all expenses occurred. I am also aware that certain services provided may not be covered by my insurance carrier. I understand that Premier Pediatrics of Louisiana will make every effort to notify me if services are known to be non-covered, but in the event that services performed are not covered, I will be responsible for payment of these services. I further understand that payment is due at the time of service, including co-payments. I give Premier Pediatrics of Louisiana permission to bill my or my child's insurance company on my behalf, and understand that any outstanding balance after my insurance company has paid in full will be my responsibility. If my account becomes past due and has to be turned over to collections, I will be responsible for additional fees to cover agency's fees.

________ **INITIALS**

Consent to Treat and/or Random Drug Screen
By signing here, I am consenting to treatment and/or random Drug Screens (when applicable) of myself or my dependent by the provider(s) of Premier Pediatrics of Louisiana. Also, I am consenting to use of photograph or audio record for the best possible treatment of myself or my dependent by the provider(s) of Premier Pediatrics of Louisiana. I understand that my medical information may be viewed or shared amongst the staff of Premier Pediatrics of Louisiana and that every effort will be made by Premier Pediatrics of Louisiana to protect my health information as is required by HIPAA regulations.

________ **INITIALS**

Consent to obtain Pharmacy Records
By signing here, I am consenting to release Pharmacy Records for myself or my dependent by the provider of Premier Pediatrics of Louisiana. I understand that my medical information may be viewed or shared amongst the staff of Premier Pediatrics of Louisiana and that every effort will be made by Premier Pediatrics of Louisiana to protect my health information as is required by HIPAA regulations.

________ **INITIALS**

Permission to Release Medical Information
By signing here, I authorize Premier Pediatrics of Louisiana to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, third-payers or their reviewing agencies. This information will be limited to that which is necessary to expedite claim processing. ***This authorization is valid for every visit to Premier Pediatrics of Louisiana until written notice revoking this authorization is provided by the patient or patient's legal representative.***

________ **INITIALS**

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Patient or Parent/Guardian Signature **Date**

If you are signing for the patient, please indicate your relationship to the patient here: ______________________________