Concord Children's Clinic
1040 Vinehaven Drive NE, Concord NC 28025
Phone: 704-784-1010 Fax: 704-784-1013
www.ConcordChildrensClinic.com

DISCLOSURES & CONSENTS

Name of Patient: _____ Date of Birth: _____

Please initial next to each statement below. Note a copy of the Notice of Privacy Policy and Financial Responsibility Statements can be found at www.ConcordChildrensClinic.com and can be given to you at the clinic upon request.

Consent to Treatment

- I hereby, consent to evaluation, testing and treatment as directed by my provider at Concord Children's Clinic.

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Release of Non-Public Personal Information

- I certify that I have made available and understand the Patient Notice of Privacy Policy. I understand that this consent is voluntary. I hereby consent to use and disclosure of non-public information that may be used and disclosed to persons other than Concord Children's Clinic to carry out their responsibilities in connection with my medical/health care treatment, evaluation, consultation, or the processing of insurance benefits. This includes school forms and/or immunization records for school purposes.

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Communication

- I certify that I understand the privacy risks of mail, phone calls and faxes. I hereby authorize Concord Children's Clinic to mail, call or fax me communications regarding my health care including but not limited to appointment reminders, referral arrangements and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Concord Children's Clinic to that effect in writing.

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Financial Responsibility

- I certify that I understand the Financial Responsibility that I hold to Concord Children's Clinic per the Financial Responsibly Statement.
- I authorize direct payment of my insurance benefits to Concord Children's Clinic. I understand that I am financially responsible for the health insurance deductible, co-insurance, and non-covered service for the patient. (Co-payments are due at the time of check in for the service)
- If my health insurance determines a service to be "non-payable", I will be responsible for the complete charge and agree to pay the cost of all services provided.
- I am uninsured at the time of visit; I agree to pay for the medical services rendered to me at the time of service.

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I have reviewed and understand the Consent & Disclosure Statements stated above.

_____	_____	_____	_____
(Name – Responsible Party)	(Signature)	(Relationship to Patient)	(Date)