

Receipt of Notice of Privacy Policies & Consent Form

Kindcare Pediatric Center

Patient Name: _____ **Date of Birth:** _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payments includes:

- (1) our submission of your health information for processing claims or obtaining payment;
- (2) our submission of claims to third party payers insurers for claims review, determination of benefits and payment;
- (3) our submission of your health information to auditors hired by third party payers and insurers; and
- (4) other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy will be updated whenever our privacy practices change. You can get a updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You also signify that you received a copy of our Notice of Privacy Practices.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obliged to agree in these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and health care operations. I acknowledge that I have received the Notice of Privacy Practices

Signature

Date

If signing as a personal representative of the patient, describe the relationship to the patient:

Relationship to Patient

Print Name