Westerville Pediatric Specialists, Inc.
575 Westar Crossing, Suite 101
Westerville OH 43082
614/508-2223

Sunbury Mills Pediatrics
700 West Cherry Street, Suite B
Sunbury OH 43074
740/965-6369

PRIVACY CONSENT

Consent for care: I, with my signature, authorize Westerville Pediatric Specialists, Inc. and Sunbury Mills Pediatrics, and any employee working under the direction of the physicians, to provide medical care for this patient for which I am the legal guardian. This medical care may include services and supplies related to this person's health and may include (but not limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information: for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice's privacy notice.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts deemed to be my responsibility by the payment sources, as required by the contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Consent related to the Privacy Statement: I have had a chance to review the Practice Privacy Statement as part of this registration process. I understand that the terms of the Privacy Statement may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse services to me if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time.

Parent/Guardian Signature _____ Date _____

Printed Name _____ Relationship _____

Copy of Practice Privacy statement signed or initiated with parent/guardian on:_____

Effective, April, 2003