lindenhurst PEDIATRICS

Acknowledgement Privacy and Financial Policy

By signing this form, I acknowledge that I have reviewed and consent to the Notice of Privacy Practices and Financial Policy of Lindenhurst Pediatrics.

I hereby give my consent for Lindenhurst Pediatrics to use and disclose protected health information about me/my children to carry out treatment, payment, or healthcare operations as outlined in the Notice of Privacy Practices.

A copy of the Notice of Privacy Practices and/or The Financial Policy may be obtained by forwarding a written request to us at 2031 E. Grand Ave. Suite 200 Lindenhurst, IL 60046, on our website, or at the front desk.

In addition, Lindenhurst Pediatrics may:

1. Call or text me at the location indicated on my executed ***patient registration form*** and leave a message on voice mail or in person, such as appointment reminders, insurance items and any topic related to clinical care including laboratory results, among others. Yes_____ No_____
2. Mail to the location indicated on my executed ***patient registration form*** any items such as appointment reminder cards and patient statements. Yes_____ No_____

Patient Name:_____ Date of Birth:_____

Parent/guardian printed name: _____ Date: _____

Parent /guardian signature: _____

This form must be filled out. I understand I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon this consent.