Dundalk Pediatric Associates
1792 Merritt Blvd.
Baltimore, MD 21222
Phone: 410-284-1133 Fax: 410-284-3371

ACKNOWLEDGEMENT OF FINANCIAL POLICY

I understand and accept the financial policy of Dundalk Pediatric Associates.

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to Dundalk Pediatric Associates all of my rights, title and interest to my medical reimbursement benefits under policy with any insurance company.

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

The practice will use your health related information for the purposes of providing you with your medical treatment, obtaining payment for services rendered and/or for general health care operations. Your health related information will be submitted through the following mechanisms: US Postal Service, Internet submission, voice mail and/or personal communications. The most common entities that will receive the information are: other providers, facilities, insurance companies and pharmacies. More specific information pertaining to our practice policies is provided for you in our "Notice of Privacy Practices" statement. You have a right to review this statement prior to receiving health care and prior to signing this consent. The terms of our Notice of Privacy practices may change at any time. You may contact the office and request a revised policy. Also, if you so choose, you may request that we restrict the use of your health information for the purposes of treatment, payment and/or health care operations. We are not required to agree with your requested restrictions. In the event we do agree with your requested restrictions, we will adhere to these restrictions. If we do not agree with your request, we will discontinue treatment.

I have received a copy of the practice's Notice of Privacy Practices and I understand that I may revoke, at any time, this consent. This revocation will not effect previous actions, prior to the revocation.

I consent to the above terms related to the use and disclosure of my individually identifiable health information for the purposes of treatment, payment and/or health care operations. I understand that this consent will remain in effect until I revoke it in writing.

_____ _____
Patient Name Patient Date of Birth

_____ _____
Parent/Guardian (Print Name) Today's Date

_____
Parent/Guardian (Signature)