Warwick
PEDIATRICS

GENERAL CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION & ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Our accompanying Notice of Privacy Practices provides details of new regulation intended to protect the privacy of patients. It describes how medical information about patients may be used and the kind of permission that patients must provide us in order to allow certain information to be used for various purposes.

The law requires us to provide you with this notice of privacy, and therefore, we need you to acknowledge that you have received it.

In addition, in order for us to continue to treat you, get paid for that treatment, and run our business, we need you to provide us with general written consent. This provides us with your permission to share your medical information with professionals involved in your case and with the health insurance company and other business associates of Warwick Pediatrics.

Generally, in order for us to disclose your health information to others, we will ask you for a separate written authorization.

By signing below, I acknowledge that I have been provided a copy of Warwick Pediatrics Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Warwick Pediatrics and how I obtain access to and control this information.
I also acknowledge and understand that I may request a copy of a separate notice that explains special privacy protections that apply to HIV, mental health and substance abuse related information.

By signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the regular health center operations of Warwick Pediatrics.

I also give permission to leave a message at the telephone number(s) I have provided.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Description of Personal Representative's Authority (Parent, Guardian)

PLEASE SIGN AND RETURN TO RECEPTIONIST

Warwick
PEDIATRICS

PERMISSION FOR OUTPATIENT MEDICAL TREATMENT AND ACKNOWLEDGEMENT FORM

Patient _____ Date _____

Permission is hereby granted to the physician and other professionals of Warwick Pediatrics to provide routine medical care for the above named patient, including assessment, diagnostic testing and rendering treatment.

This consent shall remain in effect for the above mentioned patient unless withdrawn in writing.

This consent does not cover evaluation and treatment associated with motor vehicle accident or work related injury or illness that is covered by no-fault workers' compensation insurance. Additional consent is required for that type of care.

I hereby certify that I have read or have had explained to me the above permission and acknowledgement statements:

_____
Patient

_____
Relationship to Patient

_____
Authorized Representative *(see below)*

The above permission is to be signed for all patients and maintained in the medical record.

It should be signed by the parent, legal guardian, next of kin, or legally appointed individual who represents the patient when the patient is:

1. Incompetent by judicial finding
2. Physically incapable
3. Mentally lacking capacity
4. A minor less then 18 years of age UNLESS:
   - *Patient is pregnant*
   - *Patient is parent*
   - *Patient has been legally married*

In addition, an individual less than 18 years of age may give consent for evaluation and treatment of a sexually transmitted disease.

Warwick
PEDIATRICS

Authorization for the use and/or Disclosure of Protected Health Information

I authorize the use and/or disclosure of my protected health information only as described below:

_____

_____

My protected health information will be used or disclosed for the following purposes (please list):

_____

_____

I authorize the following persons to **disclose** my protected health information

_____

_____

_____

I authorize the following persons to **receive** my protected health information

Warwick Pediatrics
3 Saint Stephens Lane, Suite 3
Warwick, NY 10990

- I understand that if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, then this information would no longer be protected.
- I understand that I have the right to revoke this authorization at any time. My revocation must be in writing and I am aware that it is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon it.

This authorization expires when acted upon, or six (6) months from date signature.

I do not have to sign this authorization in order to receive treatment from Warwick Pediatrics.

I have read and understand the above and I authorize disclosure of my protected health information as described.

_____ _____
Signature Date

_____ _____
Name of Patient Patient's Date of Birth

_____ _____
Name of Personal Representative * Relationship to Patient

*Parent, legal guardian, next of kin, or legally appointed individual who represents the patient when the patient is:

5. Incompetent by judicial finding
6. Physically incapable
7. Mentally lacking capacity
8. A minor less then 18 years of age UNLESS:
   - *Patient is pregnant*
   - *Patient is parent*
   - *Patient has been legally married*

In addition, an individual less than 18 years of age may give consent for evaluation and treatment of a sexually transmitted disease.

Authorized Warwick Effective June 2006

Warwick
PEDIATRICS

INSURANCE WAIVER

Warwick Pediatrics has informed me that procedure(s) performed today, may not be fully reimbursed by my insurance company, as they may not be a covered benefit with my policy. I have also been informed it is my responsibility to be sure that I have given the office my correct and current insurance information, that Dr. Berlingieri is a participating doctor with my insurance plan, and that he is listed as my child's primary care physician.

Although my insurance company may reduce/deny the procedure (s), I have advised the physician to proceed with the services deemed necessary and I will assume full responsibility for payment.

_____
Name of Patient

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Description of Personal Representative's Authority (Parent, Guardian)

PLEASE SIGN AND RETURN TO RECEPTIONIST