

2715 OSLER DRIVE – GRAND PRAIRIE, TX 75051
T 972-206-2940 F 972-602-7261
EMCATURAYMD.COM

Financial Policy

Authorization to Release Information: I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

I have read and understand the financial policy of Pediatric and Adolescent Center of Grand Prairie & Arlington (PACGPA) and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

New Policy on Appointments and Call Back Numbers – March 2007

I have read and understand the changes to the Appointment and Call Back Number policies of Pediatric and Adolescent Center of Grand Prairie & Arlington (Epifania Caturay, MD et al) and agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

PATIENT CONSENT FORM

I understand that as part of my healthcare, Pediatric and Adolescent Center of Grand Prairie & Arlington (Epifania Caturay, MD et al) originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information is utilized to plan my child's care and treatment, to bill for services provided to my child, to communicate with other healthcare providers and other routine healthcare operations, such as assessing quality and reviewing competence of healthcare professionals.

The PHYSICIAN'S *Notice of Privacy Practices* provides specific information and complete description of how my child's personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that the PHYSICIAN reserves the right to change the *Notice of Privacy Practices*. Prior to implementation of the revised *Notice of Privacy Practices*, the revised *Notice* will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my child's personal health information for treatment, payment, or healthcare operations and that the PHYSICIAN is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent the PHYSICIAN has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

___ I request the following restrictions on the use and/or disclosure of my child's personal health information.

I further understand that any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed the PHYSICIAN'S *Notice of Privacy Practices*.

Signature of Patient's Legal Representative

Date



2715 OSLER DRIVE – GRAND PRAIRIE, TX 75051
T 972-206-2940 F 972-602-7261
EMCATURAYMD.COM

Fill in address if you would like changes to the *Notice of Privacy Practices* sent to you:

PATIENT PROTECTED HEALTH AUTHORIZATION

Please list the family members of any other person, if any, whom we may inform about your child’s general medical condition and your diagnosis.

Please list the family members, if any whom we may inform about your child’s medical condition ONLY IN AN EMERGENCY.

Please indicate if you want all correspondence from our office sent in sealed envelope marked “CONFIDENTIAL”.

Please print the telephone number where you want to receive calls about your appointments, lab results, or other health care information (if other than your home phone number).

() _____, Cell () _____

Fax () _____, Other () _____

Can confidential messages (i.e. appointment reminders, lab results) be left on your home answering machine or voicemail? Yes _____ No _____

If you do not have voicemail, can a confidential message be left at your place of employment? Yes _____ No _____

I have read and acknowledge all Office Policies of Pediatric and Adolescent Center of Grand Prairie & Arlington.

I AUTHORIZE PEDIATRIC AND ADOLESCENT CENTER OF GRAND PRAIRIE & ARLINGTON TO FAX MY CHILD’S IMMUNIZATION RECORD SHOULD I REQUEST IT.

PATIENT NAME(S)

PARENT OR GUARDIAN’S NAME _____

PARENT OR GUARDIAN’S SIGNATURE _____

TODAY’S DATE _____