Notice of Privacy Practices Acknowledgement, "HIPAA" and Financial Policy

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers, who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice to Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that All About Kids Pediatrics has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain the current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

I also certify I have read, understand, and agree to adhere to All About Kids Pediatrics, S.C.'s Financial Policy.

Please list all children in your family that attend this practice for care:

Child's Full Name	Date of Birth

Your Name (please **print**):_____

Your relationship to Patient:_____ Same address as patient? Yes/ No (if no, please give address to front desk)

Your social Security Number: (**required** if you'd like us to bill insurance on your behalf, otherwise payment for service is due in full at the time of your visit): _____

Insurance Policy Holder Name (please print)_____

Relationship to Patient:_____ Same address as patient? Yes/ No (if no, please give address to front desk)

Policy Holder Date of birth:_____ Policy Holder SSN:_____

Your Signature:_____ Date: _____