TANASBOURNE PEDIATRICS

PHONE: 503.690.8195 FAX: 503.629.5806
17895 NW EVERGREEN PL, STE 110, BEAVERTON, OR 97006

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I received a copy of the healthcare notice of privacy practices.

_____ _____/_____/_____
Patient Name DOB

X_____ _____/_____/_____
Signature of Patient, Parent, or Legally Responsible Person Date

Consent for Treatment: I authorize the physicians and clinic personnel of Tanasbourne Pediatrics, LLC to conduct physical examinations and routine services, order and perform tests, and administer treatment deemed necessary by the examining physician. Should treatment be performed, the physician will fully inform me as to the nature of the procedure, the alternatives to treatment, and the risks involved. I will be given opportunity to ask questions and have my questions answered. Should special procedures be indicated, I understand that the examining physician will discuss this with me and that additional consent(s) may be required.

Assignment of Benefits: I authorize my insurance carrier(s) to remit payment of benefits for any claim to Tanasbourne Pediatrics, LLC. I understand that any ineligible or non-covered expenses are my responsibility.

I assign Tanasbourne Pediatrics, LLC, as an Authorized Representative to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, (3) initiate formal complaints to state or federal agency that had jurisdiction over my benefits, and (4) release all medical information necessary to process my claims. I authorize any plan administrator or insurer to release any and all plan documents, insurance policy, and/or settlement information upon written request from Tanasbourne Pediatrics, LLC. This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare, and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

NOTICE OF FINANCIAL POLICY ACKNOWLEDGEMENT

I acknowledge that I received a copy of the Tanasbourne Pediatrics Financial Policy.

_____ _____/_____/_____
Patient Name DOB

X_____ _____/_____/_____
Signature of Patient, Parent, or Legally Responsible Person Date