Welcome To
Kennesaw Pediatrics
Your Home for Pediatric Healthcare!

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Parent/Patient Authorization Signatures

Patient Name(s):

Last Name _____ **First** _____ **M.I.** ____ **DOB** _____ **M** ____ **F** ____

Please initial all applicable spaces. If a category does not apply you, please write "N/A" in the space.

Initials

Financial Responsibility

____ I have received a copy of Kennesaw Pediatrics, P.C. Financial Policies statement. I understand that insurance coverage is not a guarantee of payment, and I agree that I am ultimately responsible for any health insurance co-payments, deductibles and any remaining balances not covered or payable by my insurance company. I understand that Kennesaw Pediatrics, P.C. is not responsible for knowing what services my plan covers and does not cover.

Insurance Responsibility

____ I irrevocably assign and transfer to Kennesaw Pediatrics, P.C. all insurance benefits covered the Kennesaw Pediatrics, P.C. services for payment of services rendered. I understand that it is my responsibility for providing a current copy of my insurance card and notifying Kennesaw Pediatrics, P.C. of any changes/additions to a patient's insurance coverage.

Authorization for Release of Information

____ I hereby authorize Kennesaw Pediatrics, P.C. to release any necessary information for the following reasons: to other physicians for continuing professional care, to any insurance company or their representatives, or otherwise as allowed by law. I release Kennesaw Pediatrics, P.C. from any liability for the release of information and I understand this release includes any and all blood and related tests, including HIV, HIB, and other diseases. This authorization is irrevocable and is not limited in time.

Authorization for Care/Treatment

____ I am aware that my child(ren) may require medical treatment when I am not able to be present. In my absence, I give the individual(s) listed below my permission to authorize any and all medical treatment(s) for my child(ren) named above. Furthermore in my absence, I give permission to Kennesaw Pediatrics, P.C. and its entire staff to examine and provide emergency treatment to my child(ren) listed above. In addition, the physician/clinic has my permission to refer my child(ren)'s emergent care and treatment to the appropriate service for the treatment of the illness or injury. Regardless of authorization, I acknowledge that I am fully responsible for payment of all charges related to my child(ren)'s care whether or not services are covered by insurance. This authorization is not limited in time.

Signature: _____ **Patient Name:** _____ **Date:** _____