ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

I understand that I am responsible for paying all the fees charged by Great Kids Pediatrics to treat me/my child which are not covered services under my insurance. I understand this means that I am responsible for paying deductibles, copays, coinsurance and any other charges for non-covered services. I authorize my insurance company to pay Abel Paredes, MD PA, and my physician directly for the fees I am charged and that my insurance covers.

I authorize Abel J. Paredes, MD, Patrice E. Crane Storey, MD, Ann S. Lee, MD, Karen L. Zorrilla, MD or designee(s) to release any and all medical and/or financial records about me or my child that may be necessary for the processing of my insurance claims, to satisfy Quality Improvement activities for any insurance carrier, claim payer, or health plan, and/or to coordinate medical services for my child.

CONSENT TO TREAT

Definitions and Explanations:

Consent to Treat: Patient's parent or guardian or designee is giving permission to the doctors, nurses, medical assistants, and other health care providers in this office to provide treatment for the patient.

If a patient is 18 years or older he/she should sign for himself/herself.

Advance Directives: Documents used to plan for end-of-life health care decisions. In Texas, there are three types of advance directives:

1. Directive to Physician
2. Medical Power of Attorney
3. Out-of-Hospital Do Not Resuscitate Order (DNR)

1. I voluntarily consent to the medical care, treatments, and diagnostic tests that Dr. Paredes, Dr. Crane Storey, Dr. Lee, Dr. Zorrilla, his/her associates, assistants, and his/her other health care providers believe are necessary for me/my child. I understand that by signing this form, I am authorizing Dr. Paredes, Dr. Crane Storey, Dr. Lee, Dr. Zorrilla, his/her associates, assistants, and his/her other health care providers to treat me/my child as long as I am a patient in this practice or until I withdraw my consent.

2. I understand that Dr. Paredes, Dr. Crane Storey, Dr. Lee, Dr. Zorrilla, or his/her associates or assistants have made no warranties, guarantees or promises to me about treatment for me/my child, or about any results or cures from any treatment.

3. This form has been fully explained to me and I have had the opportunity to ask questions about it.

4. I have/my child has an advance directive (Advanced Directive to Physician, Medical Power of Attorney and/or Out-of-Hospital DNR).

   ____YES ____NO If yes, I will provide a copy for my/my child's medical record and will notify Dr. Paredes, Dr. Crane Storey, Dr. Lee, or Dr. Zorrilla in writing if I revoke my/my child's directives.

5. Was translation provided?

   ____YES ____NO

Printed Name of Patient: _____ Date of Birth: _____

Signature of Parent/Guardian/Patient:_____ Date: _____

Printed Name of Paren/tGuardian/Patient:_____

Signature of Witness: _____