# Medical and Financial Treatment Agreement

Patient or someone acting for the patient agrees to the following terms of The Pediatric Endocrine & Diabetes Clinic, PC (PEDC):

1. **MEDICAL TREATMENT:** By signing this agreement, you are giving PEDC and its physician the permission to establish medical care for you/your child, to perform physical examination, order laboratory and/or radiology tests, and to start necessary treatment. Patient authorizes PEDC to perform services ordered by the doctor. Special consent forms may be needed. This Medical and Financial Treatment Agreement is effective for this outpatient visit and/or for recurring outpatient services of the same type for the duration the patient is seen by the PEDC doctor following its execution.
2. **RELEASE OF INFORMATION:** PEDC may disclose all or any part of the patient's medical and/or financial records as permitted by law. Please refer to the "Notice of Privacy Practices" for more information. . This will also serve as an authorization for release of my/my child's medical record to emergency department, urgent care, hospital and/or other specialist, which may be necessary to further my child's medical care

   **FINANCIAL RESPONSIBILITIES:** I agree that in return for the services provide to myself/my child by PEDC, I will pay/arrange with my insurance to pay the account of myself/my child to PEDC. I hereby authorized payment directly to The Pediatric Endocrine & Diabetes Clinic, PC for services rendered and the release of any information necessary to process claims for said services and authorization to release records pertaining to my treatment to my insurance company or other 3rd parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan, via voice, electronic, mail or fax transmission. **I UNDERSTSAND THAT I AM FINANCIALLY RESPONSIBLE FOR MY NON-COVERED SERVICES**. I also agree to pay all non-covered services and/or co payments at the time of service. In the event of default, I promise to pay all legal fees, collection costs, and/or interests as may be required for this collection. If I have any further questions I can contact the office manager at 602-277-1117. This acknowledgement will remain in effect permanently.

   PEDC welcomes Personal checks as a form of payment; however, a fee of $25.00 will be applied to the patient's account if the check is returned by your Financial Institution.

   Patients that cancel their appointment **must** provide a notice of 1 business day prior to their scheduled appointment time. Failure to do so will result in a charge of $25.00 to their account.

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**(Please initial)** ________ **I have received written information about Patient Rights.**

________ **I have received a copy of the "Notice of Privacy Practices."**

________ **I authorize PEDC to leave medical information regarding my child on my voice mail.**

**Patient Name** **Date of Birth** **Witness**

**Name of: Parent of Minor Child / Court-Appointed Guardian Patient-Appointed Agent / Statutory Surrogate** **Date** **Time**

**PLEASE CICRLE THE CORRECT TITLE**