CONSENT TO TREAT, PRIVACY ACKNOWLEDGEMENT, AUTHORIZATION TO PAY MEDICAL BENEFITS, AUTHORIZATION TO RELEASE INFORMATION FOR PAYMENT PURPOSES, AND PRIVACY NOTICE ACKNOWLEDGEMENT.

1. **CONSENT TO ROUTINE MEDICAL CARE. I** _____

Patient/Legal Guardian/Representative

voluntarily consents to routine medical care at Montgomery and/or Prattville and/or Clanton Pediatric Associates, P.A. as may be deemed necessary or advisable in the judgment of my **"physician, nurse practitioner or Physician Assistant"** (hereinafter inclusive: "Provider") in Montgomery and/or Prattville and/or Clanton Pediatric Associates, P.A. Under the general and special instructions of the attending Provider(s) or other consulting Provider(s), this may include routine diagnostic procedures considered to be necessary, whether tests or otherwise, but is not limited to laboratory procedures, blood tests, x-ray procedures, medical treatment or procedures, or other services rendered the patient. Patient has the right to refuse specific treatments or procedures. The patient understands and acknowledges that no guarantee or assurance has been made as to the results that may be obtained. During the course of your care at Montgomery and/or Prattville and/or Clanton Pediatric Associates, P.A. you may be referred to a physician that is not employed by Montgomery and/or Prattville and/or Clanton Pediatric Associates, P.A. but has contracted with Montgomery and/or Prattville and/or Clanton Pediatric Associates, P.A. to use our clinic location to see their patients in Omak. Further, the patient realizes that among those who attend patients at Montgomery and/or Prattville and/or Clanton Pediatric Associates, P.A. are medical, nursing, and other health care personnel under the general and specific instructions of the attending Provider(s) or other consulting Provider(s).

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2. **PRIVACY NOTICE ACKNOWLEDGEMENT. I acknowledge that I have received a copy of the Notice of Privacy Practices of Montgomery and/or Prattville and/or Clanton Pediatric Associates, P.A.**

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3. **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:** The patient hereby authorizes and consents to the release of information related to treatment, including medical, phycological and/or drug and alcohol related diagnoses and procedures, AIDS, or other sexually transmitted disease, and laboratory results, to the practitioners or medical organizations responsible for follow-up care as well as to insurance companies or third party payors **for the purpose of payment** of Montgomery and/or Prattville and/or Clanton Pediatric Associates, P.A. The patient authorizes the Department of Social and Health Services to directly inform Montgomery and/or Prattville and/or Clanton Pediatric Associates, P.A. of the patient's status as it relates to Medicaid eligibility should the patient pursue eligibility for medical coverage through one or more of the State's programs.

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4. **PAYMENT RESPONSIBILITY:** I (we) individually and as a community hereby promise to pay for Montgomery and/or Prattville and/or Clanton Pediatric Associates, P.A. and Provider services rendered to the patient registered hereon. I understand that I will receive a bill from Montgomery and/or Prattville and/or Clanton Pediatric Associates, P.A., and separate bills from individual providers for any services performed. This may include charges from medical specialists for required consultations. I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the Provider for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. I understand it is my responsibility to pay any CO-PAY, DEDUCTIBLE, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PARTY PAYOR WITHIN A REASONABLE PERIOD OF TIME NOT TO EXCEED 90 DAYS. Should any of these accounts be referred for collection, the undersigned shall pay all court costs, reasonable attorney's fees, and collection expense (33.33%).

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5. **NON-SMOKING POLICY:** I understand that Montgomery and/or Prattville and/or Clanton Pediatric Associates, P.A. has adopted a non-smoking policy which prohibits smoking within the building and premises of Montgomery and/or Prattville and/or Clanton Pediatric Associates, P.A.

_____ **initials**

Annual Signature: _____ **Date:** _____

Montgomery and/or Prattville and/or Clanton Pediatric Associates, P.A. does not discriminate on the basis of age, sex, marital status, race, creed, color, national origin, source of payment or the presence of any sensory mental or physical handicap.