PEDIATRIC & ADOLESCENT MEDICINE OF DELRAN

INSURANCE AUTHORIZATION FORM

I, certify that I have insurance coverage with _____and is assigned directly to Dr. Pascale Bastien. All insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges, whether or not they are covered by my insurance carrier.

PRIVACY PRACTICES ACKNOWLEDGEMENT & CONSENT

I, hereby give my consent for **Pediatric and Adolescent Medicine of Delran** to use and disclose protected health information (PHI) about my child to carry out treatment, payment and health care operations. I have been provided an opportunity to review the Notice of Privacy Practice, which describes such uses and disclosure more completely.

PERMISSION FOR EXAMINATION AND TESTS

I hereby request, and permit that my child be given the examination and tests recommended by the provider. I permit this office to contact me by telephone when necessary.

PERMISSION TO TREAT IN YOUR ABSENCE

In the event that I am unable to accompany my child for medical care the following people are permitted:

☐ Uncle ☐ Aunt ☐ Grandparent ☐ Neighbors ☐ Other

☐ Sister/Brother (17 & Over) ☐ babysitter ☐ Step Mother/Step Father

I understand that I may revoke this authorization in writing at any time.

Parent Signature:

Today's Date: _____