



## Caring Pediatrics Associates

37 Meridian Road  
Levittown, NY 11756  
Office 516-796-4433 Fax 516-796-4288

### ACCEPTANCE OF POLICIES

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

#### Patient Privacy Practices

By signing below, I am acknowledging that I have received a copy of Caring Pediatrics Associates Patient Privacy Policy. I understand that it is my responsibility to read, understand and abide by the policy as presented to me.

\_\_\_\_\_  
Legal Guardian or patient signature

\_\_\_\_\_  
Date

#### Patients' Bill of Rights

By signing below, I am acknowledging that I have received a copy of Caring Pediatrics Associates Patients Bill of Rights. I understand that it is my responsibility to read, understand and abide by the policy as presented to me.

\_\_\_\_\_  
Legal Guardian or patient signature

\_\_\_\_\_  
Date

#### Patient Responsibilities

By signing below, I am acknowledging that I have received a copy of Caring Pediatrics Associates Patients Responsibilities. I understand that it is my responsibility to read, understand and abide by the policy as presented to me.

\_\_\_\_\_  
Legal Guardian or patient signature

\_\_\_\_\_  
Date

#### Financial Responsibilities

I understand that I am responsible for payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. I further understand that payment is due at the time of service, and under the law, this includes co payments. I give permission to Caring Pediatrics Associates to bill my insurance company on my (or my child's) behalf, and understand that the outstanding balance, after the insurance company has paid, will be my responsibility. In the event that my account becomes past due, there may be penalty charges and my account can be turned over to collections. I will be responsible for any additional fees and penalties for such service.

\_\_\_\_\_  
Legal Guardian or patient signature

\_\_\_\_\_  
Date

#### Permission to Release Medical Information

By signing here, I authorize Caring Pediatrics Associates to release information from my (or my child's) medical record, to my/their insurance company, third party payers or their reviewing agencies. This information will be limited to that which is necessary to expedite claim processing. This authorization is valid for every visit to Caring Pediatrics until written notice revoking this authorization is provided.

\_\_\_\_\_  
Legal Guardian or patient signature

\_\_\_\_\_  
Date