Acknowledgement Form

Notice of Privacy Practices, Financial Policy, Assignment of Benefits / Consent to Treat

Patient Information

Patient's Name: _____ DOB: _____
Last MI First

Notice of Privacy Practices

I have reviewed Kaleidoscope Kids "Notice of Privacy Practices", which explains how my/my child's medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Financial Policy

I have reviewed Kaleidoscope Kids "Financial Policy", which explains payment for services rendered by Kaleidoscope Kids is my responsibility. Any charges that are not covered by my insurance and are within their contractual limits are to be paid within 30 days of notification.

Office Policy

I have reviewed Kaleidoscope Kids "Office Policy", which explains the office rules with which each family should become familiar.

Assignment of Benefits / Consent to Treat

Consent to Treat/Consent to Treat a Minor: I hereby authorize Kaleidoscope Kids/Meredith A. Byington, MD, P.A. and/or any provider or staff to perform whatever examination, diagnostic studies, treatment or counseling necessary to provide appropriate medical care to me/my child.

Texas Law-Healthcare Workers: In the event of any healthcare worker exposure to a patient's blood or body fluids, Texas law provides and I agree Kaleidoscope Kids may perform a test on said person's blood or body fluid to detect communicable disease.

Insurance Authorization: I hereby authorize Kaleidoscope Kids/Meredith A. Byington, MD, P.A. to furnish my insurance carrier with information concerning my/my child's illness and treatment. I also authorize electronic transmission of my insurance claim to the carrier.

Assignment of Benefits: I hereby assign Kaleidoscope Kids/Meredith A. Byington, MD, P.A. all payment for surgical and medical services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by my insurance.

Authorization to Display Photos: I hereby give Kaleidoscope Kids/Meredith A. Byington MD, P.A. authorization to display any photos in the office or Kaleidoscope Kids website that I have submitted.

By signing below, I am confirming that I understand and agree with the above statements and that all information is true to the best of my knowledge.

Signature: _____ Date: _____

Relationship to Patient: _____

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