Acct # _______________

Acknowledgements and Authorizations

Patient Name: ____Date of Birth: _______________________
Phone #: ____

Notice of Privacy Practices Acknowledgement

I acknowledge that I have been offered a copy of the Wasatch Pediatrics Notice of Privacy Practices to read and/or review. I have been given the opportunity to read this Notice and ask questions. Wasatch Pediatrics will make available for me a copy of the current Notice upon my request. The current version will also be available at www.wasatchpeds.net. I understand that this Notice may be revised from time to time without notice and that I am entitled to receive a copy upon my request.

Initials _______________

Procedure Policy

It is possible that your insurance plan may require a copay, deductible and/or the following services may not be covered. If you have questions regarding this, please contact your insurance prior to having the service performed. This list is not all-inclusive or exhaustive. It is your responsibility to know your policy and coverage.

Wart Treatment/Removal Laceration Foreign Body Spirometry Immunizations
Ear Wax Removal Circumcision Drug Testing Burn Care Fracture Care MChat

Initials _______________

Authorization to Provide Consent and Receive Information

I authorize the following individuals (other than a parent or legal guardian) to provide consent for treatment for the above-named patient in my absence. These individuals may also have access to medical or financial information regarding the above-named patient. If patient is over 18 years, parents must be listed to receive information.

Name: ___________________________________ Phone #: ___________________________ DOB: ______________________
Name: ___________________________________ Phone #: ___________________________ DOB: ______________________

Initials _______________

Two Way Communication

I authorize the use and disclosure of the above-named individual's health information between Wasatch Pediatrics and the following provider(s). This is used for non-medical providers such as a psychologist or other mental health provider.

Provider Name: ___________________________________ Provider Name: ___________________________________

Unless otherwise revoked, this two-way communication authorization will expire on the following date: ___ /___ /___
Month Day Year

This authorization includes the entire medical record, including coordination of care (or case consultation) except for the following restrictions and/or exclusions:

____

____

Initials _______________

____ _________________________________

Parent / Guardian Signature **Date**

____ ____

Printed Name Witnessed by Wasatch Pediatrics Employee