GREEN HILLS PEDIATRIC ASSOCIATES (GHPA)
18 AND OVER

Patient Name: _____ **Date of Birth:** _____

Billing Address: _____

Patient's Phone: _____

Consent to Treat
I am 18 years old or older and legally recognized as an adult. I agree for GHPA and its physicians to provide medical care to me anytime I am in need of care.

Financial Responsibility
I agree to provide my insurance card at each visit and pay all co-pays, co-insurance, deductibles, and non-covered expenses associated with my medical treatment. I will be liable for these, even when a parent/guardian provides my insurance coverage. I understand that GHPA may refer any uncollected balance to an outside collection agency.

Acknowledgement of Receipt of the Notice of Privacy Practice
I acknowledge that I have received the Notice of Privacy Practices from GHPA. This notice describes how GHPA may use and disclose my protected health information.

Consent to Speak with Parent/Guardian
☐ I give permission for GHPA physicians and staff to speak with my parent(s)/guardian(s) regarding **all** of my medical information.

Please list parent(s)/guardian(s) that we may speak to and their relationship to you.
1.

2.

3.

4.

☐ I **do not** give permission for GHPA physicians and staff to speak with my parent(s)/guardian(s) regarding **all** of my medical information. I understand that if my parent/guardian provides my insurance coverage he/she may have access to the insurance explanation of benefits (EOB) and the bill from GHPA unless I pay in full at the time of service. _____ Initial

This agreement is effective as long as I am a patient at GHPA, or until I present a written statement to the contrary.

Patient Signature: _____

Date: _____

Office Use – Documented in PCC _____ (Employee Initials)