UPPER VALLEY PEDIATRICS, PLLC
BRADFORD, VT & EAST THETFORD, VT.

INSURANCE ASSIGNMENTS & AUTHORIZATION TO RELEASE INFORMATION

CONSENT TO TREAT AUTHORIZATION: I, the below named patient, parent or guardian, do hereby give Upper Valley Pediatrics, PLLC medical staff consent for medical treatment.

RELEASE OF INFORMATION:
I hereby authorize any physician/medical provider of Upper Valley Pediatrics, PLLC examining and/or treating me to release to any third payer (such as an insurance company or governmental agency, example: Blue Cross Blue Shield of VT, Medicaid or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

PHYSICIAN INSURANCE ASSIGNMENT:
I certify that, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

I certify that I, or my dependents listed, have insurance coverage as indicated and assign directly to Upper Valley Pediatrics, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the use of this signature on all insurance submissions as well as to release information necessary for the payment of claims.

MEDICARE/MEDICAID:
Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration, Centers for Medicare and Medicaid Services or its intermediaries or carries any information needed fora related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORGINAL WHICH IS SCANNED INTO MY FILE AT UPPER VALLEY PEDIATRICS OFFICES. This assignment will remain in effect until revoked by me in writing.

It is noted that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedure, and others pay a percentage of the charge. I understand it is my responsibility to pay any deductible amount, copay, co-insurance, or any other balance not paid for by my insurance or third payer within a reasonable period of time not to exceed 60 days. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

PATIENT(S) NAME(S)_____

X_____ DATE_____
Signature [**PARENT / GUARDIAN (if patient is a minor child)]/SUBSCRIBER (if different from patient)**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____(print name) have received and/or reviewed a copy of Upper Valley Pediatrics, PLLC Notice of Privacy Practices.

SCAN SIGNED FORM INTO PATIENT(S) RECORD(S)