The Pediatric Center

Acknowledgement
Privacy and Payment Policy

By signing this form, I acknowledge that I have reviewed and consent to the Notice of Privacy Practices and Payment Policy of The Pediatric Center.

I hereby give my consent for The Pediatric Center to use and disclose protected health information about me/my children to carry out treatment, payment, or healthcare operations as outlined in the Notice of Privacy Practices.

A copy of the Notice of Privacy Practices and/or The Payment Policy may be obtained by forwarding a written request to us at 556 Central Avenue, New Providence, NJ 07974, on our website, or at the front desk.

In addition, the Pediatric Center may:

1. Call or text me at the location indicated on my executed ***patient registration form*** and leave a message on voice mail or in person, such as appointment reminders, insurance items and any topic related to clinical care including laboratory results, among others. Yes______ No______
2. Mail to the location indicated on my executed ***patient registration form*** any items such as appointment reminder cards and patient statements.

Parent/guardian printed name: ____ Date: _____________________

Parent /guardian signature: ____

This form must be filled out in-person at our office. I understand I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon this consent.