Central IL Pediatric Associates LLC consent form

Notice for Privacy Practices acknowledgement receipt

Your name and signature on this form below indicates that you have received a copy of **Central IL Pediatric Associates LLC office's** Notice of Privacy Practices on the date and time indicated below.

EHx Authorization

Your name and signature on this form below indicates that you authorize **Central IL Pediatric Associates LLC** to use and/or disclose a copy of patient's protected health information in the **Electronic Health Information Exchange (eEHX)** for the purpose of coordinating patient's medical care amongst patient's healthcare providers. You understand that including this information in eEHX enables any provider with authorized access to the eEHX to review patient's protected health information, including the specially protected health information.

You acknowledge that you have been given sufficient information and have had the opportunity to have your questions answered about the Electronic Health Information Exchange (eEHX).

You understand that future withdrawal of permission to include this information in the Electronic Health Information Exchange (eEHX) will be effective except to the extent action has already been taken in reliance on this permission. When you withdraw permission your health information will be inactivated and the eEHX and will no longer be able to be accessed. This permission will expire if the eEHX program is discontinued.

You understand that patient's eligibility for treatment or any health care benefits cannot be conditioned on whether you sign this authorization form.

Authorization to Release Information

Your name and signature on this form indicates that you authorize **Central IL Pediatric Associates LLC** to release any medical or incidental information that may be necessary for either medical care or in processing financial benefit.

Consent for Vaccine Administration

Your name and signature on this form below indicates that you have read or have had explained to you the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). You have had a chance to ask questions which were answered to your satisfaction. You understand the benefits and risks of the vaccine(s) and request that the vaccine(s) recommended by American Academy of Pediatrics given to patient for whom I am authorized to make this request.

Assignment of Insurance Benefits

Your name and signature on this form below indicates your request that payment of authorized benefits be made on your behalf to **Central IL Pediatric Associates LLC (CIPA)** for any services furnished to the patient by CIPA physicians and health care providers, and you assign your right to receive these payments to CIPA.

You authorize CIPA to file an appeal on your behalf, for any denial of payment and/or adverse benefit determination related to services and care provided.

If your Health Insurance Plan will not direct payment to CIPA, you agree to forward to CIPA all health insurance payments, which you receive for the services rendered by CIPA and its health care providers.

You also certify that the insurance information that you have provided is accurate and complete as of the date of service. You acknowledge that you are responsible for keeping it updated and that no other coverage or insurance exists.

You acknowledge that your insurance company may not pay 100% of the amount of the medical claim and you may be responsible for any and all amounts not payable by your insurance company including any portion paid and not applied to in network benefits for any out of network services.

AUTHORIZATION OF REPRESENTATIVE

☐ Check box if you want to opt out of eEHX.

I, _____ do hereby state that I am authorized to sign this permission on behalf of the patient, _____ DOB: _____ on the following basis:

Relationship to Patient _____ Signature:_____

Date: Time: