PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Meel Pediatrics** to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Meel Pediatrics' *Notice of Privacy Practices* provides a more complete description of such uses and disclosures.

I have the right to review the *Notice of Privacy Practices* prior to signing the consent.

Meel Pediatrics reserves the right to revise its *Notice of Privacy Practices* at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Meel Pediatrics** Privacy Officer at 33 Lawrence Street, Methuen, MA 01844.

With this consent, **Meel Pediatrics** may call my home or other alternative location and leave a message by voicemail, text, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, **Meel Pediatrics** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, **Meel Pediatrics** may mail/email/text to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Meel Pediatrics** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I consent to **Meel Pediatrics'** use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Meel Pediatrics** may decline to provide treatment to me.

_____ _____

Patient's Name Signature of Patient or Legal Guardian

_____ _____

Print Name of Patient or Legal Guardian Date

CONTINUE ON THE BACK

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have received a copy of Meel Pediatrics' Notice of
Patient Name
Privacy Practices.

_____ _____
Signature of Patient Date

FINANCIALLY RESPONSIBLE PARTY:

Due to certain limitations that come with insurances you might have to pay out of pocket for services to receive treatment. Based on your deductible you may be held responsible for the remaining balance that goes towards your deductible. If at all you find yourself having difficulty with a certain balance, or come to find out that certain services/treatments are not covered by your insurance. Meel Pediatrics understands the financial hardship that families may have due to insurance charges and deductibles. Please consult with the office to discuss prices or payment plans.

Name:_____ DOB:_____
Relationship to patient:_____
Home Phone:_____ Cell:_____
Address:_____ City:_____ State:_____ Zip:_____

This person is responsible for ALL costs associated with care that are not covered by the insurance and/or payments if there is a lack/lapse of insurance.
This information is accurate and true to the best of knowledge. I understand that I am responsible to pay for services rendered.

Print name:_____

Signature:_____ Date:_____
