Drs. Roth, Rotter & Laster

637 Washington Street • Suite 202 • Brookline MA 02445
(617) 232-2811

FAMILY NAME: _____

CHILDREN: _____

CONSENTS

I understand that when I request care for my child's medical condition, I consent to and permit the performance of routine diagnostic procedures, medical examinations, immunizations, care, and treatment.

AUTHORIZATION TO RELEASE AND DISCUSS MEDICAL INFORMATION

I authorize the release of medical and other information associated with my child's treatment at this facility requested by my insurance company, or other third party, for payment or review purposes to the requesting party. I also authorize release of medical information to physicians and others involved in my child's care, other hospitals, facilities, or agencies in order to facilitate appropriate care. I authorize the discussion of pertinent medical information with my physician's colleagues in order to address completely any medical issues.

ASSIGNMENT OF BENEFITS

I understand that it is my responsibility to ensure that all requirements of my insurance plan have been met and I have been notified that I will be financially responsible if all requirements of my plan have not been met.

I agree to pay any and all balances for service furnished to me or the above named patient that are not covered by insurance and designated by the insurance company as payable by patient.

I understand that I am to notify this office of all insurance changes immediately, and if I fail to do so I will take full responsibility for all charges incurred during the period when the office was not notified.

1. I am aware that a "Notice of Privacy Practices" which describes the new federal regulations for disclosure and use of personal health information (HIPAA) is posted in this office
2. I understand that the new HIPAA regulations prohibit this office from faxing or sending information or forms to any camp, school, or daycare without my prior written authorization
3. I understand that my insurance plan requires that I pay a co-payment at each visit. If I don't a $10 surcharge will be added.
4. I understand that I must get referrals from this office after making the appointment but BEFORE seeing any specialist or I will be responsible for the specialist's charges.
5. I understand that if I miss an appointment at this office without canceling there will be a $50 charge.

Signed: _____

Date: _____