OLENTANGY PEDIATRICS, INC.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEGEMENT FORM

I, ____________________, have received a copy of Olentangy pediatrics, Inc.'s Notice of Privacy Practices.
Patient's Name

____ ________________________
Signature of Patient/Legal Guardian Date

RECEIPT OF NOTICE OF OFFICE REGULATIONS AND GUIDELINES

I, ____________________________, have received a copy of Olentangy Pediatrics, Inc.'s Office Regulations and
Patient/Legal Guardian
Guidelines.

____ ________________________
Signature of Patient/Legal Guardian Date

RELEASE AUTHORIZATIONS

I authorize release of any and all medical information necessary for claim submission or payment of services. I also hereby request that the payment of authorized insurance benefits be made to Olentangy Pediatrics, Inc. for any services furnished to me or my child by the associated physicians. I assume responsibility for any balance not covered by my insurance policy, including charges for any after hours service fees including Saturday visits.

Parent/Legal Guardian Signature: ____

I understand that Olentangy Pediatrics, Inc. may share my child's private healthcare information with other health professionals, in the course of healthcare treatment of my child. I acknowledge that Olentangy Pediatrics, Inc. has made a commitment to protect the private healthcare information of my family. However, I understand that the patient's name will be called in the waiting room at the time of our appointment.

Parent/Legal Guardian Signature: ____