

Lancaster Pediatric Associates, Ltd.

WILLIAM R.A. BOBEN, JR., M.D.
STEVEN F. KILLOUGH, M.D.
SHAKTHI KUMAR, MD.
PIA BOBEN FENIMORE, M.D.

BRENT D. PAWLSON, M.D.
JILL F. HIGH, M.D.
JASON L. GOTTLIEB, M.D.
CARRIE S. EDWARDS, M.D.

MARY E. DEPOE, CRNP
ELIZABETH A. NEUMANN, CRNP
TREVA M. STANTON, CRNP
GLORIA J. CISSNE, CRNP
AMANDA C. WERT, CRNP

PROTECTED HEALTH INFORMATION CONSENT AND FINANCIAL RESPONSIBILITY FORM EFFECTIVE SEPTEMBER 2008

PATIENT INFORMATION:

Last Name First Name Middle Initial DOB

Home Address City State Zip

PARENT/LEGAL GUARDIAN INFORMATION:

Name/Relationship Social Security # Employer

Home Address City State Zip

Home Phone Cell Phone

Name/Relationship Social Security # Employer

Home Address City State Zip

Home Phone Cell Phone

AUTHORIZATION FOR RELEASE OF INFORMATION: By listing any name you are hereby permitting Lancaster Pediatric Associates, Ltd. to discuss and/or disclose the above Patient's personal protected health information with the individual(s) stated below until the Patient or Parent/Guardian inform Lancaster Pediatric Associates, Ltd. in writing that permission is no longer granted.

Emergency Contact Name(s)/Relationship (to include: Grandparent-Sibling-Other Relative-Caregiver-Neighbor – Please note after name)

Emergency Contact Name(s)/Relationship (to include: Grandparent-Sibling-Other Relative-Caregiver-Neighbor – Please note after name)

INSURANCE AUTHORIZATION: I the undersigned authorize payment of medical benefits to Lancaster Pediatric Associates, Ltd. for any services furnished to me by the group. I understand I am financially responsible for any amount not covered by my insurance plans contract. I also authorize you to release, to my insurance company, information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefit.

Responsible Party Signature

Date

Please date and initial

____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____
Date-Initial Date-Initial Date-Initial Date-Initial Date-Initial Date-Initial Date-Initial Date-Initial Date-Initial