Cranial Kids
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Medical Information Release Form

HIPPA Release Form

Patient Name:_____ Date of Birth: ____/____/____

Consent to Treat and Authorization to Release Information

Initial:

_____ I authorize the **release of information** acquired in the course of my treatment, including, but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, and/or other third party payer.

_____ I authorize **phone messages** regarding my treatment and appointments to be left with persons or machines at the phone numbers I have provided.

_____ I acknowledge that I have been offered a copy of Cranial Kids **Statement of Privacy Notice**.

_____ I consent to **evaluation and treatment** by Cranial Kids, LLC and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

(This Release of information will remain in effect until terminated by Cranial Kids in writing)

Payment Policy

Initial:

_____ **PATIENTS WITH INSURANCE:** You will be responsible for paying your annual deductible, copayment or co-insurance and any charges for NON-COVERED SERVICES as indicated on the explanation of benefits (EOB) and per your insurance plan.

_____ **ACCOUNT STATEMENTS:** Statements are mailed at the beginning of each month. If two statements are mailed to the patient indicating a patient balance is due, and no payment has been received or no contact is made by the patient to arrange a payment schedule, the account will be turned over to our collection agency.

Patient's Signature _____ Date _____

_____ _____ Date _____

Signature of Responsible Party (If different than patient) Relationship