ADVANCED NEIGHBORHOOD PEDIATRICS, LLC.
12239 Cypress Spring Rd, Clarksburg, MD 20871
1111 Spring Street, Ste 220, Silver Spring, MD 20910

Consent for Services

Patient Name____ **Date of Birth**__________________

AUTHORIZATION FOR TREATMENT:
I authorize Advanced Neighborhood Pediatrics, LLC. to provide treatment to myself or the above named patient.

NOTICE OF PRIVACY PRACTICES:
I have been given a copy of Advanced Neighborhood Pediatrics, LLC.. Privacy Practices in compliance with HIPAA legislation.

ASSIGNMENT OF BENEFITS:
I authorize my insurance company to pay and hereby assign directly to Advanced Neighborhood Pediatrics all benefits, if any, otherwise payable to me for services. This authorization may be revoked by either me or my insurance company at any time in writing.

REFERENCE LABORATORY SERVICES:
I understand that Advanced Neighborhood Pediatrics, LLC.. utilizes the services of an outside lab to perform some of the lab tests requested by its physicians. I further understand that the Reference Laboratory will bill separately for its services. I consent to Advanced Neighborhood Pediatrics providing demographic information as necessary for billing purposes.

CANCELLATION OF APPOINTMENTS
I understand that I must give a 24 hour notice to cancel my appointment. I further understand that future services may be denied if I fail to keep my scheduled appointments and may be charged for not canceling or showing up for my appointment.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:
I authorize release of copies of pertinent medical records to providers outside of Advanced Neighborhood Pediatrics, LLC. who are being consulted with and/or I am being referred to in connection with my current treatment, to insurance companies for the purpose of determining benefits for services provided, and to reference laboratories for billing purposes.

AUTHORIZATION FOR RELEASE FOR RESEARCH OR QUALITY IMPROVEMENT:
Maryland Law requires us to inform you that a copy of your medical record, no matter when created, may be released to outside groups for medical research or quality improvement purposes unless you object. Researchers cannot use patient names or identifying characteristics when reporting any results of their research. We evaluate these requests to ensure that the release of patient records is necessary to accomplish the research purpose.

PAYMENT AGREEMENT/COLLECTION POLICY:
I, the undersigned, do hereby expressly guarantee payment of all charges for medical services rendered, or to be rendered by Advanced Neighborhood Pediatrics, LLC. I understand that it is my responsibility to provide Advanced Neighborhood Pediatrics with current insurance information. I understand that a finance charge of 8 % per annum is charged to any balance 60 days or older on my account. I will be responsible for the balance due, plus any costs that are incurred by S Advanced Neighborhood Pediatrics, LLC. in collecting my account.

NON VIOLENCE POLICY
I understand that Advanced Neighborhood Pediatrics, .is committed to providing its employees with a safe, nonviolent workplace and reserve the right to determine whether particular conduct violates this policy or is otherwise inappropriate.

USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION
●My insurer may share my past, current and future health and account records with Advanced Neighborhood Pediatrics, LLC.. about services I've received from Advanced Neighborhood Pediatrics, LLC. and other care providers unrelated to Advanced Neighborhood Pediatrics, LLC. These records may be used by Advanced Neighborhood Pediatrics, LLC. as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

●______My insurer **MAY NOT RELEASE** any of my identifiable health records from providers unrelated to Advanced Neighborhood Pediatrics, LLC. for the purposes described above.

By signing this form, I am consenting to treatment and agreeing to these policies. I understand this authorization will remain in effect until I revoke it in writing.

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Date	*Signature Patient (if 18 yr.) / Parent / Legal Guardian*	*Relationship to Patient*