ACKNOWLEDGEMENTS AND PERMISSION FORM

SOUTHLAKE PEDIATRICS, INC.
5000 Southlake Park #250
Birmingham, AL 35244
Ph# 205-982-2500/Fx#205-982-2574

Name of Patient(s):____
(Please print)

SECTION I – Acknowledgement of Receipt of *Notice of Privacy Practices*

____*(please initial)* I have received a copy of the ***Notice of Privacy Practices for Southlake Pediatrics***
*Southlake Pediatrics reserves the right to modify the privacy practices outlined in *The Notice of Privacy Practices**

SECTION II – Acknowledgement of Receipt of *Notice of Policy and Procedures*

____*(please initial)* I have received a copy of the ***Policies and Procedures form for Southlake Pediatrics.***
Southlake Pediatrics reserves the right to modify the policies and procedures at any time

SECTION III – Acknowledgement and Acceptance of Cancellation Policy
The policy of Southlake Pediatrics for appointment cancellations is as follows:

- Well-child and ADD evaluation office visits must be cancelled within 24 hours of scheduled appointment time. ***Patient will be liable for a $25 scheduling fee per child*** for cancellations less than 24 hours in advance. *This fee is not billed to Medicaid patients, however, in all cases both for private insurance as well as Medicaid, it is our policy to terminate the patient-physician relationship after three (3) no-show appointments for a family*.

____*(please initial)* By signing below, I certify that I have read and accept Southlake Pediatrics Cancellation Policy. I realize that my insurance *will not* compensate me these fees.

SECTION IV – Acknowledgement and Acceptance of Financial Responsibilities

____*(please initial)* I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that charges not covered by insurance remain my responsibility and assign insurance benefits to Southlake Pediatrics, Inc. In the event an account is not paid within 90 days, I agree to pay collection fees ($10 certified mail fee, reasonable collection agency fees not to exceed 33 1/3 % & possibly attorney's fees) and hereby waiver all rights of exemption under the constitution of the state of Alabama.

SECTION V – Acknowledgement of Vaccine Policy Statement

____*(please initial))* I have received a copy of the ***Southlake Pediatrics Vaccine Policy Statement***
- I understand the firm belief in immunizing children that Southlake Pediatrics physicians take with vaccines. I am aware that I can ask questions in order to alleviate any fears I have with vaccinations. I understand that if I refuse to immunize my child that I will be asked to find another physician that shares my philosophy.

X____
Signature of Patient or Patient Representative (*if patient is a minor or unable to sign this form).* **Date**

Relationship of Patient Representative to Patient(s): ________________