

Hamblen Pediatric Associates, Inc  
Authorization Form

**Patient's Name** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Please Print)

**Assumption of Responsibility:** I agree that in consideration of services to be rendered I obligate myself, assume financial responsibility and agree to pay upon demand to Hamblen Pediatric Associates, Inc (HPA) all charges for such services and incidentals incurred. Should the account be referred to an attorney for collection, I shall pay reasonable attorney fees and collection expenses. Even though insurance may be filed, I understand that all bills are payable upon receipt and that I and not the insurance company, am responsible for the payment of all services. Furthermore, I understand that if I fail to give insurance information at the time of service and later give the information that I will be responsible for payment if the insurance does not pay.

**Initial:** \_\_\_\_\_

**Responsibility for Co-pay Amounts:** I agree to be fully responsible for paying co-pays at the time of physicians visit. Further, I understand that if my co-pay is a percentage, I will be responsible for payment immediately after insurance benefits have paid. This meaning that any bill received once insurance is paid, will be due upon receipt.

**Initial:** \_\_\_\_\_

**Primary Care Physician:** I agree to be responsible for payment of all office visits and services rendered if my insurance company requires my child to be assigned to a primary care physician (PCP) and I have listed a physician other than one at Hamblen Pediatric Associates, Inc. I understand that HPA will try to verify my child's PCP but it is my responsibility to take my child to the PCP assigned to my child.

**Initial:** \_\_\_\_\_

**Assignment of Insurance Benefits:** I hereby assign direct payment of any insurance benefits including medicare, TennCare, major medical insurance or third party payor to Hamblen Pediatric Associates, Inc.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Acknowledgement of Receipt of Privacy Notice:** I acknowledge receiving a copy of Hamblen Pediatric Associates, Inc notice of privacy policies. I consent to Hamblen Pediatric Associates, Inc use of protected health information as described in the notice for treatment, payment, or health care operations. I understand that I must provide a separate authorization before any other disclosure may be made.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Child:** \_\_\_\_\_ **Date:** \_\_\_\_\_