# R & R PEDIATRICS, PLLC

**Location: HWY 55**
3100 NC HWY 55 Ste# 202
Cary, NC 27519
Phone: (919) 367-9833
Fax: (919) 367-9832

**Location: Carpenter Fire Station**
7560 Carpenter Fire station Rd Ste#201
Cary, NC 27519
Phone: (919) 367-9834
Fax: (919) 367-9832

## Patient Consent and Acknowledgment Form

[For Use and Disclosure of Protected Health Information (PHI)]

**Patient Name:** _____ **DOB:** _____ **Chart Number:** _____

- I understand that as part of my healthcare, R & R PEDIATRICS, PLLC originates and maintain health records describing my health history, examination, diagnosis, treatment, test results, and any plans for future care and treatment. I also understand this information serves as:
  - A basis for planning my care and treatment
  - A means of communication among the many healthcare professionals who contribute to my care
  - A source of information for applying diagnosis and surgical information to my bill
  - A means by which third party payer can verify that services billed were actually provided
  - And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
- I understand that the patient's health information is private and confidential. I understand that R & R PEDIATRICS, PLLC works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.
- I understand and have been provided with a detailed document "Notice of Privacy Practices" that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent.
- I understand the practice reserves the right to update this acknowledgement and change their notice and practices. If I ask, R & R PEDIATRICS, PLLC will provide me with the most current notice of Privacy Practices.
- I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance upon my prior consent. Any patient, guardian or personal representative has the right to request to receive confidential communications of protected information by alternative means or at alternative locations. Such request must be in writing and the practice must accommodate reasonable request.
- I understand that R & R PEDIATRICS, PLLC uses family billing and that information for all members of the family members appear on one statement. With this consent, R&R PEDIATRICS, PLLC may continue to use such billing. Divorce has no bearing on the responsibility for medical care as it affects third parties. Whoever brings the child is expected to pay the charges due for the services rendered that day. R & R PEDIATRICS does not get involved in payment disputes between parents.
- I understand that private insurance or Medicaid cards should be presented at every visit.
- With this consent, R&R PEDIATRICS, PLLC may call mobile, my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO (Treatment, Payment, and Healthcare Operations), such as appointment reminders, insurance items and any call pertaining to my health care, including laboratory results among others.
- With this consent, R&R PEDIATRICS, PLLC may e-mail or mail to my home or other designated location, any items that assist the practice in carrying out TPO, as described above.
- I also understand that I have the right to request R&R PEDIATRICS, PLLC restrict as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. However the practice is not required to agree to the restrictions requested, but if it does, it is bound by this agreement.
- My signature below indicates that I have been given the chance to review a current copy of R&R PEDIATRICS, PLLC' notice of Privacy Practices and consenting to R&R PRDIATRICS, PLLC to use and disclose my PHI to carry out TPO.
- **I understand that if I do not sign this consent, R&R PEDIATRICS, PLLC have right not to provide medical care to me.**

**Signature:** _____ **Today's Date:** _____
(Patient, Parent or Legal Guardian)

**Name of Person Signed**: _____ **Relation to Patient:** _____
(If Other than Patient)