DR. MANDI'S INTEGRATIVE PEDIATRICS, LLC

Signature Page

Patient's Name: _____

Date of Birth: _____

I. Consent for Treatment

I authorize Dr. Mandi's Integrative Pediatrics, LLC ("The Clinic") and Dr. Anandhi Mandi to provide ongoing medical care, treatment, and procedures as needed including emergency care for the patient listed above. I understand that no guarantees can or will be made as to results of care, treatment, or medication prescribed. If the patient is a minor, then I represent the parent or guardian of the patient listed above. Proxies for medical consent (others who may bring the child in for medical visits) include the following in addition to the parents or legal guardians of the child: _____

II. Financial Agreement

I understand and agree that I am financially responsible for all services provided. As a courtesy, The Clinic may bill my insurance carrier. Regardless of outstanding insurance claims, full payment is due upon receipt of bill. Copays are due at the time of service. If collection procedures are required, I am responsible for their cost. Some services may not be covered by insurance policies and they remain my responsibility.
I acknowledge and understand that body fluids and tissues collected by this clinic, will be sent to a lab, and that I will receive a separate bill from them for their services.

III. Assignment of Benefits

I authorize my insurance benefits be paid directly to Dr. Mandi's Integrative Pediatrics, LLC. I certify that all information given in applying for payment under my health insurance plan is correct and authorize verification of coverage by Dr. Mandi or staff. A photocopy of this authorization shall be considered as effective and valid as the original. If

my insurance information changes, I will provide the new information prior to receiving additional care. If my insurance coverage is not in effect at the time I receive care, or if my plan does not cover the services that I have received, I will be responsible for the charges.

IV. Consent to Release of Information

I authorize Dr.Mandi's Integrative Pediatrics, LLC to release upon request to my insurance carriers or other reimbursing agencies information about my identity, treatment, diagnosis, prognosis, and/or other services rendered including information about substance abuse, HIV/AIDS, or other sexually transmitted or reportable diseases as permitted by law, thus releasing Dr.Mandi's Integrative Pediatrics and Dr.Mandi's and staff of any liability for furnishing such information. I understand that information may be released through electronic or paper media.

V. Notice of Health Information Practices

I acknowledge that I have been provided with access to or a copy of the Notice of Privacy Practices (see Website)

VI. Approved Methods of Communication: (please circle your choices)

I do/ do not consent to the leaving of **voice mail** regarding medical results and appointment reminders.
I do/ do not consent to the sending of **e- mail** appointment reminders.

VII. Acknowledgement of Practice Policies:

I hereby acknowledge that I have reviewed or will immediately review the practice policies as posted on Dr. Mandi's Integrative Pediatrics, LLC practice website, and agree to abide by these practice policies while under the care of Dr. Mandi. This includes but is not limited to policies on missed appointments, refills, narcotics, terms for termination of care, and after-hours care.

Signature of Patient or Guardian: _____

Date: _____

Printed Name: _____