

Patient Consent, Authorization and Agreement
Bravo Pediatrics, LLC
Pediatrics@Nite, LLC Dulles Town Center
21010 Dulles Town Circle; Dulles, Virginia, 20166

Welcome to our practice. This document contains the information required by Law and many Health Plans to protect your child's rights, inform you of his/her rights and your responsibilities. We are sorry that it is of such length, but we must comply with the terms and conditions that are imposed upon us so that we may serve you. By signing this form you are granting consent, authorizing and agreeing to the following terms and conditions :

Consent to Treat: I, as the legal guardian and legal representative of the minor named below, authorize and request Bravo Pediatrics, LLC to provide medical care to the child or minor reasonable by today's standards at Pediatrics@Nite, LLC.

Our Notice of Privacy Practices : I acknowledge receipt of Privacy Practices which provides more detailed information about how Bravo Pediatrics, LLC and its agents may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this clause, and we encourage you to read it in full. You may obtain a copy of the current and revised notice by: accessing our web site www.pedsatnite.com, any computer in the exam rooms or contacting our office. You may also take the written copy of the notice with you. You do not need to acknowledge receipt of our notice in order to receive care. Initials : _____ Date: ____/____/2004.

Assignment of Benefits : I hereby assign to Bravo Pediatrics, LLC any insurance or other third-party benefits available for health care services provided to the minor. I understand that Bravo Pediatrics, LLC has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Bravo Pediatrics, LLC, I agree to forward to Bravo Pediatrics, LLC all health insurance and other third-party payments that I receive for services rendered to the child immediately upon receipt. I further state that the insurance information provided is accurate and the Health Plan does cover the child, and acknowledge that I'm been extended credit based on the written information provided. I also understand that making a false statement in order to be granted credit for services provided today constitutes a crime against The Commonwealth of Virginia.

Insurance Coverage Waiver : I understand that my child's or minor's eligibility for coverage by his/her insurance company cannot be confirmed at this time. I wish for him/her to receive medical service from Bravo Pediatrics, LLC. If it is determined that I or the minor's child is not eligible for coverage, the health plan denies payment, the service is not covered by your health plan or it is applied to your deductible; I understand that I will be solely responsible for payment of all services provided today plus all collections fees, late fees and interest that may apply.

Referral Waiver : I did not bring a referral for the medical services the minor will receive today. If the minor's primary care physician does not provide a referral within two business days, I understand that I am responsible for paying for the services I am requesting.

MAMSI PATIENTS : As an enrollee in a MAMSI HMO product, I understand and agree that I need to provide BRAVO PEDIATRICS with a referral within 2 business days of the date of service. If I fail to provide the written referral, I'm solely responsible for all the charges incurred today and any applicable fees. I also acknowledge and agree that if MAMSI denies payment or fails to pay the claim within 45 days, I'm responsible for payment at a discounted rate.

ADVANCE BENEFICIARY NOTICE (ABN): insurance companies or health plans do not pay for all of your health care costs. Insurance companies or health plans only pay for "medically necessary" or "covered" items and services when the insurance company or health plan rules are met. The fact that the insurance company or health plan may not pay for a particular item or service does not mean that your minor should not receive it. There may be a good reason your minor's doctor recommended it or you are requesting it. You are responsible for knowing and will advise the agent(s) of Bravo Pediatrics, LLC of items that are not covered by the insurance policy covering the care of the minor. I want the minor to receive these items or services. I agree to be personally and fully responsible for payment of all such services.

Payment for Services : I agree to be solely responsible for all performance and payments of all charges incurred today because of my request for medical services including but not limited to co-pays, deductibles and other term specifically listed above. Payment is due at time of service. I agree that any balance due to Bravo Pediatrics, PLLC that is not paid within 30 days of today's date will be subject to interest at the rate of (1%) per month, plus cost of collection including but not limited to reasonable attorney's fees. I understand that all unsettled accounts are turned over to collections after 45 days.

Pharmacy Services : Pediatrics@Nite and Bravo Pediatrics, LLC provide a pharmacy service for your minor. You are not obligated to fill your prescription in our facility. However if you would like to have the prescription filled in our facility please sign your prescription and return to us. Initials _____

Credit Card Pre-Payment: I agree to enter into a pre-payment plan by signing a credit card form and authorizing Bravo Pediatrics, LLC to bill my credit card for a total up to \$150 in two monthly equal installments, if the minor is not covered or the health plan refuses payment. Initials _____

Name of Minor or Child Patient: _____ D.O.B. ____/____/____

I certified that I have received a copy of this authorization, consent and agreement. I further warrant that I'm the legal and personal representative of the above named minor. The undersigned is herein referred to as legal representative, legal guardian, I and/or you.

By : _____ Date: _____ 2005
Signature

Print : _____
Name of Personal Representative Legal Guardian

Relationship to Patient : _____