

**WESTERN WAKE PEDIATRICS, P.A.  
PATIENT REGISTRATION FORM  
DISCLOSURES & CONSENTS**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby authorize direct payment of my insurance benefits to Western Wake Pediatrics, P.A., or the physician individually, for services rendered to my dependents by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that my insurance carrier has determined should be payable to Western Wake Pediatrics, P.A..

**MEDICAID/CHAMPUS INSURANCE BENEFITS:**

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my dependent's records that these programs may request. I hereby direct that payment of my dependent's authorized benefits be made directly to Western Wake Pediatrics, P.A., or the physician on my behalf.

**AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:**

I certify that I have received and read a copy of the Patient Notice of Privacy Policy. I hereby authorize Western Wake Pediatrics, P.A., or the physician individually to release any of my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

**AUTHORIZATION TO MAIL, CALL OR E-MAIL:**

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Western Wake Pediatrics, P.A., representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Western Wake Pediatrics, P.A., to that effect in writing.

**LAB/X-RAY/DIAGNOSITC SERVICES:**

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services from another facility. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

**CONSENT TO TREATMENT:**

I hereby consent to evaluation, testing, and treatment as directed by my physician or his or her designee at Western Wake Pediatrics, P.A..

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

GUARANTOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(If different from patient)

GUARANTOR NAME (Please Print): \_\_\_\_\_