

CARTERSVILLE PEDIATRIC ASSOCIATES, P.C.

PATIENT NAME: _____

GUARANTOR NAME: _____

I HEREBY AUTHORIZE CARTERSVILLE PEDIATRIC ASSOCIATES TO FURNISH ANY INFORMATION TO INSURANCE CARRIERS, OTHER PHYSICIANS, OR CONCERNED PARTIES CONCERNING ILLNESSES OR ACCIDENTS. I UNDERSTAND THAT THESE RECORDS MAY BE EITHER MAILED, FAXED, OR ELECTRONICALLY FILLED. I DO NOT HOLD CARTERSVILLE PEDIATRIC ASSOCIATES RESPONSIBLE FOR ANY ERRORS IN TRANSMISSION.

I HEREBY ASSIGN TO THE PRACTICE ALL PAYMENTS FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE. IF COLLECTION BECOMES NECESSARY, THE UNDERSIGNED SHALL PAY ALL COSTS, INCLUDING ATTORNEY'S FEES.

PLEASE LIST BELOW ANY PERSONS, OTHER THAN THE GUARDIAN, THAT WILL BE BRINGING THE PATIENT TO CARTERSVILLE PEDIATRIC ASSOCIATES FOR MEDICAL TREATMENT. IF SOMEONE WHO IS NOT ON THIS LIST BRINGS THE PATIENT TO CARTERSVILLE PEDIATRIC ASSOCIATES, THEY MUST HAVE A NOTE FROM THE GUARDIAN GIVING PERMISSION TO SEEK MEDICAL TREATMENT.

MOTHER/FATHER OR LEGAL GUARDIAN'S SIGNATURE

DATE

Office Location:

Cartersville Pediatric Associates at Cartersville
970 JF Harris Parkway, Suite 350 · Cartersville, Georgia 30120

Cartersville Pediatric Associates at Lake Pointe
3950 Cobb Parkway, NW, Suite 701· Acworth, GA 30101