

**For the following patients of New Beginnings Pediatrics:**

Name \_\_\_\_\_ DOB \_\_\_\_\_  
Name \_\_\_\_\_ DOB \_\_\_\_\_  
Name \_\_\_\_\_ DOB \_\_\_\_\_  
Name \_\_\_\_\_ DOB \_\_\_\_\_

I acknowledge that the “**Financial Policy**” for New Beginnings Pediatrics is available for my review at NBPeds.com

I understand it is my responsibility to read and follow those policies.

**Signature of Guarantor** \_\_\_\_\_ **Date** \_\_\_\_\_

I acknowledge that the “**Group Practice**” policy for New Beginnings Pediatrics is available for my review at NBPeds.com.

I understand it is my responsibility to read it

**Signature of Guarantor** \_\_\_\_\_ **Date** \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS AND COLLECTION AUTHORIZATION:** *PLEASE BE ADVISED THAT WE REQUIRE PAYMENT AT THE TIME OF SERVICE. THE UNDERSIGNED AGREES THAT ALL SERVICES ARE RENDERED ON A PAID BASIS ONLY. IF OUTSIDE COLLECTION BECOMES NECESSARY, THE UNDERSIGNED SHALL PAY ALL COSTS INCLUDING INTEREST AND ATTORNEY'S FEES. THE UNDERSIGNED AUTHORIZES THE RELEASE OF INFORMATION RELATING TO CLAIMS FOR THE BENEFITS SUBMITTED ON BEHALF OF DEPENDANTS OR ME. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE MY SIGNATURE ON THIS DOCUMENT AUTHORIZES MY PHYSICIAN TO SUBMIT CLAIMS FOR BENEFITS VIA U.S. MAIL OR ELECTRONIC DATA SUBMISSION FOR SERVICES RENDERED WITHOUT MY SIGNATURE ON EACH AN EVERY CLAIM TO BE SUBMITTED FOR MYSELF OR MY DEPENDANTS AND THAT I WILL BE BOUND BY THIS SIGNATURE AS THOUGH THE UNDERSIGNED HAD PERSONALLY SIGNED THIS PARTICULAR CLAIM. I ALSO HERBY ACKNOWLEDGE FULL RESPONSIBILITY FOR MY ACCOUNT WITH THIS OFFICE.*

**Signature of Guarantor** \_\_\_\_\_ **Date** \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Dated April 14, 2003

I acknowledge and agree that I have received a copy of New Beginnings Pediatrics’s Notice of Privacy Practices.

**Patient Legal Representative/Parent** \_\_\_\_\_ **Date** \_\_\_\_\_

\_\_\_\_\_  
Print Name of Legal Representative

\_\_\_\_\_  
Relationship to patient