ACKNOWLEDGEMENT OF PRIVACY PRACTICES/FINANCIAL DISCLOSURE

I understand that I have the right to restrict how my Health Information (defined below) is used or disclosed by Cook Children's Physician Network (hereinafter referred to as "CCPN") to carry out treatment, payment, or health care operations. I may seek to restrict these uses or disclosures by designating my restrictions on this form; however, I understand that CCPN is authorized by federal law to refuse to abide by my requested restrictions and that restrictions on use of Health Information for payment, treatment, or health care operations may prevent me from receiving medical services at CCPN.

RELEASE OF INFORMATION: I consent and authorize CCPN and any practitioner providing medical goods and services to patient to release information contained in any financial records and/or medical records, including diagnosis and treatment at CCPN or by any practitioner providing medical goods and services to the patient, including but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), Hepatitis A, B and C, drug/alcohol abuse and treatment, psychiatric diagnosis and treatment records and/or laboratory tests results, medical history, treatment progress, and/or other such related information (collectively "Health Information") for the purpose of payment, treatment, or health care operations to one or more of the following:

1. Insurance Company, self-funded or health plan, its agents, representatives, attorneys or independent contractors, Medicare, Medicaid, any other person or entity that may be responsible for paying or processing for payment any portion of my CCPN bill or conducting utilization management / review and financial/ medical audits;

2. To any person or entity affiliated with or representing CCPN and any practitioner providing medical goods and services to patients for the purpose of payment, treatment and health care operations;

3. To any other hospital, nursing home, or other health care institution to which the patient is transferred;

4. Patient's primary, attending, consulting, referring, and/or family physician for follow up, physician information and/or continuity of care to include prospective or current home health company, to referring facility health care staff or to CCPN.

In addition, I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy Notice, a copy of which has been provided to me. I have read or will read the Privacy Notice and ask CCPN if I have any questions about the information contained in the Privacy Notice. I agree to the uses/disclosure of me/my child's Health Information as described in the Privacy Notice. Moreover, I understand that the Privacy Notice may be amended by CCPN from time to time and that I may obtain an amended Privacy Notice at any time by contacting CCPN's registration/front office personnel.

I give permission for the release of Health Information to be transmitted by U.S. Mail, facsimile or other electronic medium. I may revoke this Consent to Release Health Information in writing at any time, unless action has already been taken in reliance thereupon; in which case, I may revoke this Consent for future communications.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS AND RIGHTS: I hereby irrevocably assign, transfer and convey to CCPN and any practitioner providing care and treatment to me/my child, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee welfare benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I receive from CCPN. If me/my child's treatment was caused by events which result in legal action, I assign to CCPN an interest in any claims I/my child may have arising from or in connection with the delivery of services by CCPN to me/my child. I hereby promise to pay for all of the services rendered to me/my child to the extent I am legally responsible for such payment. I understand I

am responsible for all health insurance co-payments and deductibles and any other amounts properly payable by me as permitted by law or contract. Charity care may be available if CCPN eligibility criteria are met.
DESIGNATION OF AUTHORIZED REPRESENTATIVE: I designate and appoint CCPN (and it's agents) as my authorized representative and authorize it to act on my behalf to (1) request and receive a copy of the summary plan description; (2) pursue a benefit claim; (3) appeal an adverse benefit determination; and/or (4) file a legal/equitable action to recover benefits from my employee welfare benefit plan, insurance policy, any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child at CCPN, any requests for documents relating to this claim and appeal of an adverse determination of the claim. This document shall remain in force until a written revocation by me is delivered to CCPN.
MEDICAID PATIENTS ONLY: I understand that the amount owed to CCPN for covered services will be satisfied by amounts paid by Medicaid for such services and that I will not be balance billed by CCPN for Medicaid covered services. I further understand that the services or items that I request to be provided to me may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for me/my child's care. I understand that the Texas Health and Human Services Commission or its health insuring agent determines the medical necessity of the services of the items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for me/my child's care. If I am a Medicaid STAR patient, I acknowledge that some of these provisions may not apply.
MEDICARE/TRICARE PATIENTS ONLY: I acknowledge receipt of the written material entitled "Important Message for Medicare/Tricare."

COORDINATION OF BENEFITS/GUARANTOR'S ATTESTATION: Most insurance companies require the patient/patient's guarantor to accurately and completely provide all primary and secondary insurance information. Failure to provide this information could result in the denial of payment of otherwise valid claims by the insurance company and may result in the patient/patient's guarantor being personally responsible for all services performed. Prior to the performance of any services, the patient's insurance coverage will be reviewed with the patient/patient's guarantor and documented in writing, which written documentation may be attached hereto and provided, if necessary, to the patient's insurer.

GUARANTOR'S ATTESTATION

I ATTEST THAT I HAVE REVIEWED THE INFORMATION SET OUT IN THE ATTACHED REGISTRATION DOCUMENT(S), THAT IT IS CORRECT, AND THAT THE INSURANCE INFORMATION NOTED IS THE ONLY COVERAGE I HAVE IN FORCE AT THE CURRENT TIME. UNLESS RECORDED ABOVE, I HAVE NO SECONDARY INSURANCE COVERAGE. I ALSO AUTHORIZE THE PHYSICIAN AND/OR OTHER PROVIDER TO RELEASE ANY INFORMATION REQUIRED TO PROCESS THIS CLAIM AS WELL AS ANY SUBSEQUENT CLAIMS FOR ANY FUTURE TREATMENT(S) UNLESS RESCINDED BY ME IN WRITING.

I hereby certify and affirm that I have the legal authority to make the above assignment of benefits and designation of authorized representative and, if other than a parent of the child receiving treatment, will provide upon request appropriate legal documentation of such authority (e.g., legal guardianship, power of attorney, court order.)

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND RECEIVED A COPY OF THE CCHCS NOTICE OF PRIVACY PRACTICES.

______________________________	______________
Patient name (please print)	Date of birth
Signature of Patient, if Adult, or Patient's Parent/Legally Authorized Representative	Relationship
Witness	Date