Randolph Pediatrics

Marisa Ciufalo, MD
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Randolph, New Jersey 07869

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Patient Name	Date of Birth
Patient Name	Date of Birth
Patient Name	Date of Birth
Patient Name	Date of Birth

Parent or guardian: Please initial each statement and sign after you have read and agreed with the following:

_____ initials

1. AUTHORIZATION

I hereby authorize Dr. Ciufalo to give my child reasonable and proper medical care by today's standards and release medical information for any kind of treatment or payment operations by the office staff of Randolph Pediatrics.

_____ initials

2. HIPPA

I understand the purpose of the Health Insurance Portability and Accountability Act (HIPPA) that became effective April 14, 2003 and acknowledge that a copy of HIPPA is posted in the office and available to me.

_____ initials

3. ASSIGNMENT OF INSURANCE BENEFITS

I authorize release of any medical information necessary to process this claim for the patient(s) above, and authorize the payment of medical benefits to the named provider for professional services rendered.

_____ initials

4. OFFICE POLICIES AND PROCEDURES

I am aware of office policies and procedures and fees that are clearly posted at the front desk. I understand that these policies, procedures, and fees may be periodically updated but will be clearly posted. I agree that I am financially responsible for any and all office fees and legal fees incurred on my family's account.

_____ initials

5. VACCINATIONS

I agree to go to www.cdc.gov or www.immunize.org for vaccination information and understand that I may ask questions prior to vaccination(s) being administered. Copies of Vaccination Information Sheets available in office.

_____ Initials _____ Parent/Guardian Signature _____ Date

_____
Print Parent/Guardian Name