



TEXAS GULF COAST MEDICAL GROUP – PEDIATRICS

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage applicable to _____ (name of child) with _____ and assign directly to Texas Gulf Coast Medical Group all medical benefits, if any, otherwise payable to me for services rendered. I authorize Texas Gulf Coast Medical Group to furnish information to insurance carriers concerning the illness of named person. This information will include treatment records, medication records, laboratory reports, history and physical and information on communicable diseases and will be used for insurance payment purposes. This authorization is valid until I revoke it. I have the right to refuse this release of information. If I refuse to release this information, I understand that I am financially responsible for all charges and must pay for services at the time of delivery. I further understand that I have financial responsibility for all services whether or not paid by insurance. I hereby authorize the use of my signature on all insurance submissions.

X _____ Yes () No ()
Signature of Parent/Guardian/Guarantor Date Check Agreement to Release Information

MEDICAID AUTHORIZATION/ATTESTATION

I request that payment of authorized Medicaid benefits be made on behalf of _____ (name of patient) to Texas Gulf Coast Medical Group for any services furnished to named patient by physicians of this Group. I authorize any holder of medical information applicable to patient to release this information to Medicaid and its agents needed to determine benefits. Such release may include treatment records, medication records, laboratory reports, history and physical and information on communicable diseases. This authorization is valid until I revoke it. I have the right to refuse this release of information. If I refuse to release the information, I understand that I cannot be provided benefits under Medicaid. My signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I attest that this patient is eligible for Medicaid coverage.

X _____ Yes () No ()
Signature of Parent/Guardian/Guarantor Date Check Agreement to Release Information

TREATMENT AUTHORIZATION

I authorize Texas Gulf Coast Medical Group to give _____ (name of patient) reasonable and proper medical care by today's standards.

X _____
Signature of Parent/Guardian/Guarantor Date

LAB INSURANCE CONSENT

I authorize and give Texas Gulf Coast Medical Group my consent to submit specimens (blood, tissue, etc.) to the laboratory (ies) of choice for analyses and study to include submission for payment to the insurance carrier for this patient and/or to me for charges incurred and agree to full responsibility and payment for any non-covered medical services. I authorize release of any clinical information including treatment records, medication records, laboratory reports, history and physical and information on communicable diseases as may be necessary for laboratory to submit information to the insurance carrier, including Medicaid. This authorization is valid until I revoke it. I have the right to refuse this release of information. If I refuse to release the information, I understand that I cannot be provided benefits under Medicaid and commercial insurance and the laboratory will require payment for services at the time of service. My signature requests that payment be made to the authorized laboratory and authorizes release of medical information necessary to pay the claim.

X _____ Yes () No ()
Signature of Parent/Guardian/Guarantor Date Check Agreement to Release Information

RESPONSIBLE PARTY AGREEMENT

I, _____ guarantor of this account, agree to pay the balance due. Should the collections department need to contact me regarding this account and are unable to reach me by mail or home phone, then I may be reached at my work phone.

X _____
Signature of Parent/Guardian/Guarantor Date

Note: Words in italics indicate those required for HIPAA compliance

Texas Gulf Coast Medical Group, PLLC

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Texas Gulf Coast Medical Group, PLLC creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a complete description of the uses and disclosures of certain health information and identifiers such as my name, date of birth, insurance card and driver's license, telephone number and address. It also explains how I may AMEND my medical records, obtain a RECORD OF DISCLOSURE or file a COMPLAINT regarding disclosure of my records. I understand that I have had the right to review the notice before signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (quality assessment and improvement activities, underwriting, premium rating conducting or arranging for medical review, legal services and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations, this includes calling me for an appointment reminder. I have the right to revoke this consent, in writing, except where disclosures have been made in reliance on my prior consent.

THIS CONSENT IS GIVEN FREELY WITH THE UNDERSTANDING THAT:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment of health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purpose of treatment, payment or health operations be restricted. I also understand that Texas Gulf Coast Medical Group and I must:
 - a. Agree to any restriction in writing that I request on the use and disclosure of my protected health information: and
 - b. Agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Patient' Name Printed Date

Patient's Signature (Or Guardian, if a minor) Social Security Number (For Identification purposes only)

Witness (Optional) Date



I give my permission for the staff of Texas Gulf Coast Medical Group to leave messages concerning lab work, biopsy results, medications, or any other medical information related to my condition with the following:

CHECK ALL THAT APPLY

Home Answering Machine

Telephone Number: _____

Work Voice Mail or Answering Machine

Telephone Number: _____

Family Member (spouse, children, parents, brother or sister)

Telephone Number: _____

Housekeeper or Nanny

Telephone Number: _____

Secretary

Telephone Number: _____

_____ I **do not** give my permission to the staff of TGCMG's office to release any medical information related to my condition, unless it is to me directly. I can be reached at the following number: _____

PATIENT'S NAME: _____

DATE OF BIRTH: _____

PATIENT OR GUARDIAN SIGNATURE: _____

DATE: _____