Coastal Pediatrics Acknowledgment Form

1. **General Office Policy:** Please note that the Well Waiting Room is designated for well-baby and well-child check-ups only. The primary purpose for this policy is to protect newborn babies and other patients who might have a weaker immune system. Please be seated in the sick waiting area if:
   a. You, your child, or any friend or family member with you has or is showing symptoms of a communicable disease or illness, e.g., a cold, a rash, flu, strep, a fever, a cough, a runny nose, etc.
   b. You are here for any reason other than a routine well visit.
   c. Your child is over the age of two. and you have elected not to vaccinate your child.

initials ______

2. **Notice of Privacy Acknowledgement:** I have the right to review the Notice of Privacy Practices prior to signing this consent. Coastal Pediatrics reserves the right to revise its Notice of Privacy Practices at any time.

initials ______

3. **Patient Rights & Responsibilities:** I have the right to request the Patient Rights & Responsibilities prior to signing this consent. Coastal Pediatrics reserves the right to revise its Patient Rights & Responsibilities at any time.

initials ______

4. **Financial Policy:** I understand my insurance may not cover all visits, e.g., preventative care, hearing & vision screenings, labs, vaccines, etc. I understand I am financially responsible for all services or fees regardless of insurance coverage. I further authorize the release of necessary information in order for Coastal Pediatrics to receive payment for services rendered. I understand I have the right to receive a detailed description of Coastal Pediatrics Financial Policy.

Initials______

5. **Custody Documentation:** I understand unless otherwise prohibited by court order or statue, all records and information pertaining to the child shall be equally available to both parents in all types of custody arrangements. Please be aware that all information will be available to both parents regardless of custody arrangements unless legal documentation is presented to Coastal Pediatrics revoking all parental rights.

initials______

6. **Minor Consent:** I understand the Alabama state law considers my child an adult at age fourteen {14) regarding medical decisions. Once my child reaches the age of fourteen (14) I understand Coastal Pediatrics must obtain a signed document, by my child, giving consent to treat and permission for releasing medical information.

initials ______

Coastal Pediatrics does not discriminate on the basis of **age**, sex, marital status, race, creed, color, national origin, source of payment or the presence of any sensory mental or physical handicap.

______________________________ ______________
Parent or Legal Guardian (Print) Date

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Signature - Parent or Legal Guardian