



**Acknowledgement of Receipt & Understanding of Policies**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Acknowledgement of Receipt of Financial Policy**

(initials) I understand and agree to the terms outlined in the MVP Kids Care Financial Policy.

**Acknowledgement of Receipt of No Show & Cancellation Policy**

(initials) I understand and agree to the terms outlined in the MVP Kids Care No Show & Cancellation Policy.

**Acknowledgement of Receipt of Notice of Privacy Practices-Confidentiality, Privacy, Participation in Health Information Exchange, and HIPAA (Health Insurance Portability and Accountability Act).**

(initials) I have reviewed and understand a copy of the MVP Kids Care Notice of Privacy Practices.

(initials) I agree to receive detailed messages relating to my Child’s health information from MVP Kids Care at:

Email address: \_\_\_\_\_ Phone number: \_\_\_\_\_ (Home/Cell).

(initials) I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider’s participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

**Acknowledgement of Receipt of Consent to Treatment**

(initials) I have reviewed and understand a copy of the MVP Kids Care Consent to Treatment.

**Authorized Individuals to Consent to Treatment and Record Information Release**

I give my permission for the person(s) listed below to bring my child(ren) in for treatment, with the understanding that they will see or hear information about your child’s medical treatment, and may possibly include protected medical, financial, or personal information included in your child’s medical record. This person(s) may be asked to consent to diagnostic procedures, immunizations, and medical treatments. This person(s) must have your/child’s insurance information (card), and must pay your co-pay, deductible, etc. And they must provide identification each time when accompanying your child(ren) to appointments. I understand that it is my responsibility to provide any and all legal documentation pertaining to guardianship or advance directives. I understand and accept the terms outlined above.

**Authorized Individuals:** \_\_\_\_\_

\_\_\_\_\_  
Name/Relationship to Child

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Name/Relationship to Child

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Name/Relationship to Child

\_\_\_\_\_  
Phone Number

**This consent for is valid for one (1) year from the date of the signature listed below.**

**I acknowledge that I am responsible for ensuring all my questions and concerns have been answered regarding any of the above policies.**

\_\_\_\_\_  
Signature of Parent/Guarantor

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date