Beachside Pediatric Associates

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Est. 2020
Beachside Pediatric Associates, P.A.

All of these terms must be agreed upon by the parent/guardian for your child to be treated at Beachside Pediatric Associates. Communication preferences can be adjusted and copies of all documents are available in clinic or at www.beachsidepeds.com

Patient_____**DOB**_____

Consent Documents

***Please initial each space to confirm that the following policy documents have been made available to you:**

_____I agree to the terms listed in the **"Financial Policy"** document.

_____I agree to the terms listed in the **"HIPPA Privacy"** document.

_____I agree to the terms listed in the **"Assignment of Benefits"** document.

_____I agree to the terms listed in the **"Release of Billing Information"** document.

Record Sharing

***Please initial each space to confirm you agree to the following:**

_____I give permission for the clinic to obtain my medication history with Surescripts.

_____I give permission for the clinic to obtain and update the patients immunization record in the state database FL Shots.

Parent/Guardian name_____

Signature_____**Date**_____