Beth Gallant, D.O.

North River Pediatrics P.C.

Greg Gallant, Clinic Manager
2589 NW Edenbower Blvd.
Roseburg, OR 97471
Phone: (541)677-6116
Fax: (541)957-5181

Patient Consent Form

Initials

I authorize the North River Pediatrics to release my child's/dependent's health information including the diagnosis and records of any products, treatment, or examination rendered to my child/dependent in order to seek payment from all third party payers including my insurance company, as well as to other health practitioners to assist in the care of my child/dependent. _____

I agree to assign to North River Pediatrics all payments I become entitled to receive for services and products provided to my child by any physician and/or nurse at North River Pediatrics. _____

I understand that I must pay all co-payments, deductibles, and other charges not covered by insurance companies or other benefit programs. I understand that if these benefits stop for any reason, I must pay for all services and products provided on my behalf to my child/dependent. I also understand that I will be charged a $25 returned check fee for any payment I make not honored by my banking institution. _____

I agree that if I do not provide complete and correct insurance or third party payer information at the time of any service provided by North River Pediatrics on my behalf to my child/dependent, including hospital care, I may have to pay charges that would otherwise be covered by insurance or other third party payer. This includes any charges incurred if my child's/dependents insurance needs a referral and I fail to acquire the necessary referral. _____

I acknowledge that I have received a copy of North River Pediatrics' Privacy Practices and I understand that I may request a copy of my child's/dependent's health information, propose changes or additions, and receive a list of non-treatment related disclosures of my child's/dependent's information. _____

If my child/dependent has a Workers' Compensation claim filed on their behalf, I authorize North River Pediatrics to release any personal health information, including information about my child's/dependent's condition and treatments, to the Workers' Compensation insurance company, my employer, and my lawyer. _____

I agree that North River Pediatrics may from time to time take photographs of my child/dependent and keep them with their medical records. I agree that all my medical providers may use these photographs for identification purposes, to prevent fraud, and to assist with my medical care. I agree that these photos will not be used for any other purpose without my expressed written permission. _____

More on Back! ⇨

I understand this office participates in the DCIPA Community Health Record System. This means the North River Pediatrics will maintain my health information, including chart notes, prescription records, operatory notes, radiographs and scans, lab results, and other health information in a secure shared record accessible to other participating community healthcare providers. My other medical providers who participate in the System do the same thing, permitting all participating providers ready access to up to date information regarding my child's/dependent's condition and care. Participating in this system allows my healthcare providers to give me better care with less hassle. _____

By initialing I authorize North River Pediatrics to include my child's/dependent's health information in the System view that portion of my personal health information maintained in the System by other providers, and make my personal health information available to other participating providers throughout the System. I understand that, with certain exceptions, if I refuse to permit my health information to be included in the System, North River Pediatrics may refuse to treat me. _____

I agree that if my child/dependent is under the age of 18, or unable to read or understand the above, this form must be signed by a competent adult responsible for the care of the patient. The responsible adult assumes all obligations above. _____

I acknowledge the importance of the provider's time and schedule. I agree that if I or my child does not show up for a scheduled appointment, or cancels a scheduled appointment within 30 minutes of the appointment time on three occasions, I will be asked to seek medical care from another clinic. _____

_____ _____
Patient Name Date of Birth

_____ _____
Patient Name Date of Birth

_____ _____
Patient Name Date of Birth

_____ _____
Signature Today's Date

_____
Relationship if not patient signature