

BAY SHORE PEDIATRICS

130 HOSPITAL ROAD, SUITE 207
PRINCE FREDERICK, MD 20678
(410) 535-5959 OFFICE
(410) 414-4662 FAX

CONSENT AND INFORMATIONAL NOTICES

I, _____, hereby give my consent for **DR. MICHAEL SKOLNICK, DR. MANBIR SINGH, AND/OR DR. MEGHAN CHIU** to see and provide medical treatment for my son/daughter.

I have been shown where the practice privacy policy is posted, and understand my right to receive a written copy.

I have been shown where the practice vaccine policy is posted and agree to abide by it.

I have received a written copy of the "Practice Handbook and Guide for Pediatric Care" and agree to abide by the policies within it.

I hereby give my consent for Dr. Michael Skolnick and/or Dr. Meghan Chiu and/or Dr. Manbir Singh to access all electronic Medical Records on the Calvert Memorial Hospital Computer System until further notice. I understand I may revoke this permission at any time.

SIGNATURE: _____ **DATE:** _____
Parent/guardian

Relationship to patient: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage with

_____, and assign directly to Bay Shore
(Name of insurance company)

Pediatrics ALL insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance within 120 days. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

In the event that my account is placed with a collection agency and/or attorney for the collection of past due debts, I understand that I will be responsible for all cost that is incurred to collect the past due debt. This does include court cost, filing fees, attorney fees and collection fees.

SIGNATURE: _____ **DATE:** _____