



Michael A. Pilz, M.D.  
Sherry Pleau, CPNP  
Brooke Elwell, PA-C  
Tammy B. Bottner, M.D.

18 Highland Avenue  
Newburyport, MA 01950  
978.465.0322  
Fax: 978.465.2503

**THIS DOCUMENT IS TO BE SIGNED BY A PERSON LEGALLY RESPONSIBLE FOR THIS PATIENT'S MEDICAL DECISIONS**

**Authorization to Treat**

I request and authorize Riverside Pediatrics and its personnel to deliver medical care to the child/children listed below as may be deemed necessary in the diagnosis and treatment of a minor child. Medical care and interventions may include, but are not limited to medical evaluation, physical exam, routine immunizations, injections, lab work, etc.

**Riverside Vaccine Policy**

Riverside Pediatrics follows the American Academy of Pediatrics (AAP) recommended schedule for well visits and vaccines and provide evidence-based care. We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as healthcare providers, and that you can perform as parents/caregivers.

**Acknowledgement of Receipt of Notice of Privacy Practices**

I hereby acknowledge that Riverside Pediatrics has provided me with a copy of its Notice of Privacy Practices that describes how medical information may be used and disclosed, and how I can access this information. Please refer to our website for a detailed copy of our HIPAA Privacy Practices Policy, or you may ask at the front desk for a copy.

**Release of Information**

I hereby authorize Riverside Pediatrics to release and disclose to my insurance carrier(s), as applicable, any information for determining benefits or benefits payable for related services and any information necessary for purpose of accreditation, audits, certification, and peer or utilization reviews. I also authorize Riverside Pediatrics to release and disclose to any other healthcare provider any information necessary in providing medical services.

**Acknowledgement of Financial Responsibilities**

There are many rules, regulations and limitations imposed by each different managed care company. I understand that it is my responsibility to provide Riverside Pediatrics with my most up to date information at the times of service. Please refer to the financial policy on our website for full details.

**Authorization to View Outside Medication History**

I hereby authorize Riverside Pediatrics to view my/my child's outside medication history.

**\*\*\* A \$25 fee will be charged for any appointment not cancelled 24 hours in advance. These fees are not covered by insurance and will be your responsibility.**

***The undersigned patient/responsible party acknowledges receipt of this form and agrees to the terms set forth.***

**PATIENT'S PRINTED NAME:** \_\_\_\_\_

**SIGNATURE OF PATIENT OR RESPONSIBLE PARTY:** \_\_\_\_\_

**RESPONSIBLE PARTY'S PRINTED NAME:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_

**DATE:** \_\_\_\_\_