SAVING GRACE HEALTH

ACKNOWLEDGEMENT FORM

Patient Name: _____ DOB: _____

ACKNOWLEDGEMENT OF DLO:

It is the patient's responsibility to know which lab, diagnostic facility or specialist in in their insurance network. If the patient does not provide the staff of Saving Grace Pediatric Concierge with the correct information, all labs will be sent to Diagnostic Laboratory of Oklahoma (DLO). Any additional charges due to being out of network will be the patients responsibility.

Parent/Guardian Name: _____ Date: _____ Signature: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND CONSENT:

A complete description of how your medical information will be used and disclosed by Saving Grace Pediatric Concierge is in our PRIVACY PRACTICES, which you should read before signing this agreement. A copy is available to you upon registration and is posted on website. By signing this agreement I acknowledge receipt of Saving Grace Pediatric Concierge and authorize the use and disclosure of my medical information as described in the Notice of Privacy.

Parent/Guardian Name: _____ Date: _____ Signature: _____

Witness: _____ Basis for Refusal, if refused: _____

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ACKNOWLEDGEMENT FORM

Witness: _____ Basis for Refusal, if refused: _____

Patient Name: _____ DOB: _____

FINANCIAL POLICY:

I have read the Financial Policy for Saving Grace Pediatric Concierge and I agree to the terms listed above.

Parent/Guardian Name: _____ Date: _____ Signature: _____

CODE OF CONDUCT:

I acknowledge Saving Grace Pediatric Concierge has the right to refuse care at any point. Grounds to terminate care include and are not limited to; need for higher level of care, provider or nurse feeling threatened or uncomfortable in person or via phone/ messaging or for any other reason determined by provider.

Parent/Guardian Name: _____ Date: _____ Signature: _____