CHESAPEAKE PEDIATRICS

PATIENT AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned, realize that I am financially responsible for all services rendered to me by **Chesapeake Pediatrics, LLC.**
For those insurance for which **Chesapeake Pediatrics LLC**, accepts assignment, I realize that I am personally responsible for all co-payments, deductibles, and non-covered services, as dictated by my insurance company.
I authorize **Chesapeake Pediatrics LLC**, to release to my insurance carrier(s)/employer/ attorney and any medical information necessary to obtain reimbursement, including mental health and substance abuse information. Without expressed revocation, this consent is valid for two years.

I permit a copy of this authorization to be used in place of the original.

Signature of Patient or Parent/Legal Guardian Date

I,_____,(parent/legalguardian)of_____,___ _____,_____,give permission for the following to bring said children to your office for medical treatment.

Name/Relationship	Telephone Number
1.	
2.	
3.	
4.	

_____ _____
Parent/Legal Guardian Date

*This form will be updated yearly. Any changes to information should be given to the front desk personnel.

CHESAPEAKE PEDIATRICS
121 OLD SOLOMONS
ANNAPOLIS, MD 21401
410-224-3663