Premier Kids Care, Inc.
Statement of Agreement
Phone 888-892-9001
Fax: 866-810-4021

Patient Name: _____ Parent Name: _____
Address: _____
Sex: Male: _____ Female: _____ Date of Birth: _____ Phone: _____
Allergies: _____
Contact Person and Phone # for reorders: _____
Employer: _____ Phone: _____
SS#_____ Email Address: _____
Emergency Contact: _____ Phone: _____

I hereby authorize Premier Kids Care (PKC) to provide products, services and other medical care as requested by me and /or as authorized by my/my child's treating physicians or other health care provider contacting PKC on my behalf. I understand that I am under the supervision and control of my/my child's attending physician. I understand that my/my child's physician is solely responsible for diagnosing and prescribing drugs, supplies, and clinical services for my/my child's condition and otherwise supervising and controlling my/my child's medical care. I have been informed by my/my child's physician as to the nature, purpose and risks involved in receiving medical therapy and now consent to its administration.

I hereby assign all benefits and payments to be paid directly to PKC for any and all types of medical care provided by PKC. It is understood that, as a courtesy, PKC and its affiliates will bill Medicaid, all other government sponsored health plans, as well as private insurance and all other health plans. I understand that this document constitutes a legally binding assignment and is not a mere authorization to collect benefits on my/my child's behalf. In the event that payments for medical care provided by PKC are made directly to me or any third party on my/my child's behalf, the payee will endorse to Premier all checks for such payment. I understand that I am responsible for providing all necessary information and forms, and for making sure all certification and enrollment requirements are fulfilled.

I hereby authorize all medical personnel to release to PKC any and all records pertaining to my/my child's medical history, medical services rendered, or treatment provided that pertains to Growth Hormone or Lupron therapy. I hereby authorize my/my child's insurer, health plan, or any other third party payer to release to PKC any and all information pertaining to my/my child's health care coverage for the purpose of establishing my eligibility for benefits payable by said insurer or payer or under said plans.

I understand and agree that I am responsible for the payments of any and all sums that may become due for the medical are provided to me/my child. These sums include, but are not limited to, all deductibles, co-payments, and co-insurance out of pocket requirements, and non-covered services. If for any reason PKC does not receive payment from my insurance carrier (s), I do hereby agree to pay PKC for the balance within 30 days of receipt of invoice. I understand that, as the policy holder, custodial parent or legal guardian, it is my responsibility to know my/my child's insurance policy regarding benefits, plans, provisions, limitations and to initiate any inquiries regarding denial of services.

I understand that, due to Federal and State Pharmacy Regulations, drugs and supplies given to the patient cannot be re-dispensed. Therefore, pharmacy products cannot be returned for credit.

I understand that a pharmacist is available for counseling. I agree to advise the pharmacy of any medication and /or dose changes and any changes in allergic condition. I acknowledge that I have received education and training specific to my/my child's assessed needs and abilities and I feel comfortable with my/my child's medication regimen.

Premier Kids care reserves the right to terminate services upon verbal or written notice.

I acknowledge that I have been provided with a copy of my patient's rights and responsibilities. **I acknowledge it is my responsibility to notify Premier Kids of any insurance and/or Medicaid changes.**

I have been apprised of my pharmacy benefits and choose to exercise the freedom of choice statute, if applicable. I am choosing PKC as my pharmacy.

The effectiveness and safety of care, treatment and services does not depend upon factors substantially unrelated to the patient's care such as age, race, color, religious preference, sex, national origin, or disability.

By Signing below I acknowledge that I have read, understand and agree to the above statement, and have received information pertaining to "Uses and Disclosures of Protected Health Information".

I hereby request that PKC may periodically use Federal Express/UPS as a designated delivery agent for my/my child's medication. By signing and dating below, I am authorizing delivery.
Patient/Parents Signature:*_____Date:* _____