Pediatric Associates Prof., LLC   Patient Information

Patient Information

Patient Legal Last Name		Legal First Name		MI	
Other Name (Nickname)		Patient DOB		Sex	M F
Mailing Address		City, Zip			
Social Security Number		How did you hear about us?			
Preferred Language	□English □Spanish □Other ______				
Ethnicity	□Hispanic □Non-Hispanic □Other ______	Race			

*APA requests information on Ethnicity/Race to meet Federal Meaningful Use criteria.

Contact Information

Guarantor	The person signing this form will be noted in our records as the "Guarantor" of the account. As such they will receive financial statements from our office. We understand that parents may have developed financial / legal arrangements regarding responsibility for medical care. We request that those arrangements be coordinated between the parents. Both parents are responsible for any financial balance although we will normally communicate with the Guarantor listed on the account.

Mother / Guardian Last Name		First Name					
Address		City, Zip					
DOB		SSN		Employer		E-mail	
Please Check Preferred Contact Phone	□Home______ □Work______ □Cell______						

Father /Guardian Last Name		First Name					
Address	(If Different From Above)	City, Zip					
DOB		SSN		Employer		E-mail	
Please Check Preferred Contact Phone	□Home______ □Work______ □Cell______ (Please check preferred contact number)						

Who is the primary caregiver of the patient?	□Both □Mother □Father □Other,(explain)______
If Applicable, Who Has Custody?	□Both □Mother □Father □Other (Please Provide Legal Documentation For Any Alternative Custody Arrangements)

Emergency Contact (Other Than Parent)	Name		Relationship		Phone #	

Insurance Information

Primary Insurance		Secondary Insurance	

Additional Family Information

Siblings of Patient Living in Household (List only if established or future patient):

Name: ______ DOB: ______ Name: ______ DOB: ______

Name: ______ DOB: ______ Name: ______ DOB: ______

Consent for Payment/Assignment of Insurance Benefits/Privacy Policy

• I understand that I am financially responsible for all professional charges that my child(ren) may incur. Payment for these services is due at the time of service. Patients covered under a contracted insurance plan are required to pay any co-payment, deductible, or co-insurance at the time of service or promptly when billed. I understand that Insurance Cards should be presented at EVERY VISIT.
• I hereby authorize payment of medical benefits directly to Pediatric Associates Prof., LLC. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance will become my responsibility unless otherwise prohibited by state or federal regulations.
• Permission to Treat a Minor (Under age 18): In the event of an emergency and I cannot be contacted, I give my permission to Pediatric Associates Prof., LLC to treat my child in their office as required by the events of that emergency situation.
• Acknowledgment of Receipt of HIPAA NOTICE OF PRIVACY PRACTICES: I have received, or have been given the opportunity to receive, a copy of HIPAA Notice of Privacy Practices for Pediatric Associates Prof., LLC.
•Text / Voice / E-mail: I authorize to use these as a way to contact me about appointment reminders.
•I authorize Pediatric Associates Prof., LLC to share immunization information with my child(ren)'s school.

______________________   ______________________

Signature   Date