GREENWICH PEDIATRIC ASSOCIATES, LLC

PATIENT INFORMATION

(No nicknames please) **TODAY'S DATE**_____

PATIENT NAME: / / M / F

_____

LAST FIRST MIDDLE **DATE OF BIRTH**

PATIENT NAME: / / M / F

_____

LAST FIRST MIDDLE **DATE OF BIRTH**

PATIENT NAME: / / M / F

_____

LAST FIRST MIDDLE **DATE OF BIRTH**

PATIENT NAME: / / M / F

_____

LAST FIRST MIDDLE **DATE OF BIRTH**

PATIENT NAME: / / M / F

_____

LAST FIRST MIDDLE **DATE OF BIRTH**

ADDRESS:

_____

ZIP CODE: _____ **CITY:** _____ **STATE:** _____

CHILDREN LIVE WITH: MOTHER FATHER GUARDIAN

HOME PHONE #: (_____) _____-_____

MOM'S NAME_____ **MOM'S DOB**_____ **MOM'S SS#**_____

DAD'S NAME_____ **DAD'S DOB**_____ **DAD'S SS#**_____

MOTHER WORK PHONE #: (_____) _____-_____ **FATHER WORK PHONE #:** (_____) _____-_____

MOTHER CELL PHONE #: (_____) _____-_____ **FATHER CELL PHONE #:** (_____) _____-_____

MOTHER EMAIL ADDRESS: _____ **FATHER EMAIL ADDRESS:** _____

REFERRED BY: _____

RESPONSIBLE PARTY INFORMATION

RESP. PARTY NAME: _____

LAST FIRST MIDDLE

ADDRESS: _____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION: COMPANY: _____

CITY & STATE: _____ PHONE #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ID#: _____ **GROUP NUMBER:** _____

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts over 90 days will be charged an interest rate of 1 1/2 percent per month (18% per annum). In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company.

INSURANCE POLICY:

You are responsible for all copays, coinsurance, deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS:

I authorize Greenwich Pediatrics, LLC to treat my child/children. I authorize payment directly to Greenwich Pediatrics, LLC for any and all medical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse Greenwich Pediatrics, LLC for any payments my insurance company may have sent to me in error. I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits. I also understand that I am responsible for advising Greenwich Pediatrics, LLC of any and all changes to my insurance coverage. I understand that co-pays are due on date of service. Failure to pay co-pay at that time will result in an additional administrative fee. Our office requires 24 hours notice for appointment cancellation and rescheduling. Failure to provide this notice will incur a cancellation fee.

I certify that the information I have provided is true and accurate. I have read the above and accept financial responsibility in full for this account.

SIGNED: _____ **DATE:** _____

Patient, Parent, or Guardian

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

ADDRESS: _____