Pediatric Care

Name of Children	Sex	Birth Date	Allergies	Primary Care Physician
	M F	/ /		
	M F	/ /		
	M F	/ /		
	M F	/ /		
	M F	/ /		
	M F	/ /		

Father

Name

Street

City State Zip

Phone Email

Social Security # Birth Date

Employer Phone

Mother

Name

Street

City State Zip

Phone Email

Social Security # Birth Date

Employer Phone

Nearest friend/relative not living with you Phone

Address

Insurance Information

Primary insurance company I.D.#

Insured name Social Security # Group #

Secondary insurance company I.D.#

Insured name Social Security # Group #

Referral Information

Referred by: ❒ friend ❒ family member ❒ doctor ❒ nurse ❒ yellow page ad ❒ other_____

Name of person who referred you (if applicable):

Address (if known, of person who referred you) Phone (if known, of person who referred you)

Please Read Carefully

By signing this form I understand and consent to the following:

- I authorize care and treatment by Pediatric Care.
- I give consent to Pediatric Care for use and disclosure of protected health information for treatment, payment, and Healthcare Operations.
- Pediatric Care may provide appointment reminders, messages may be left with family members, or on the family answering machine.
- The person who brings in the child is responsible for payment. (We do not collect from ex-spouses, etc.)
- Pediatric Care will bill my insurance as a service to me. I give my authorization for payment to be remitted directly to Pediatric Care.
- I am personally responsible for the balance of my account after 60 days.
- Unpaid balance over 120 days will be sent to a collection agency.
- A $20.00 fee will be assessed for all returned checks.
- A $25.00 fee will be assessed for a scheduled appointment no canceled 24 hours ahead.
- I have received a copy of Pediatric Care's Notice of Privacy Practices.

Responsible Party Signature_____Date_____