PARENT AND INSURANCE INFORMATION

PARENT INFORMATION

Mother's Information

Mother's Name: _____ _____ _____
LAST FIRST MI

Mother's Address: _____ Apt # _____

City _____ State _____ Zip _____

Mother's Home Phone #: ( )_____ Work #: ( )_____ Cell #: ( )_____

Mother's Email Address: _____

Mother's Work Place: _____

Address: _____

City _____ State _____ Zip _____

Mother's Date of Birth: _____ Mother's Social Security #: _____

Mother's Marital Status: S M D W Mother's Race: _____ Ethnicity: _____ Preferred Language: _____

Father's Information

Father's Name: _____ _____ _____
LAST FIRST MI

Father's Address (if different from above): _____ Apt # _____

City _____ State _____ Zip _____

Father's Home Phone #: ( )_____ Work #: ( )_____ Cell #: ( )_____

Father's Email Address: _____

Father's Work Place: _____

Address: _____

City _____ State _____ Zip _____

Father's Date of Birth: _____ Father's Social Security #: _____

Father's Marital Status: S M D W Father's Race: _____ Ethnicity: _____ Preferred Language: _____

Insurance Information

PRIMARY INSURANCE

Company Name: _____ Copay Amount $_____

Subscriber Name: _____ _____ _____
LAST FIRST MI

Subscriber Date of Birth: _____ Social Security #: _____

I.D.# _____ Group # _____ Effective Date: _____

SECONDARY INSURANCE

Company Name: _____ Copay Amount $_____

Subscriber Name: _____ _____ _____
LAST FIRST MI

Subscriber Date of Birth: _____ Social Security #: _____

I.D.# _____ Group # _____ Effective Date: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone #: ( ) _____ Cell #: ( ) _____

Name: _____ Relationship: _____

Phone #: ( ) _____ Cell #: ( ) _____

I hereby give authorization for medical treatment by CHILDREN'S CARE PEDIATRICS (CCP) and I understand that I am fully responsible for payment of services including co-pays, co-insurances, and out-of-pocket expenses and that insurance is filed as a courtesy. I further understand that by CCP filing my insurance, that it does NOT constitute a contract between the physician and my insurance company. I authorize my insurance carrier to make payment to CCP for services rendered.

Patient/Insured Signature _____ **Date** _____

I hereby authorize the release of my medical records/documents to my insurance company, physicians, or other entities necessary in the collection and/or processing of my medical claim.

Patient/Insured Signature _____ **Date** _____

HIPAA

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.
- To review and receive a paper copy of our privacy practices.

( ) I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

Patient

_____ _____ _____

Signature of Patient or legal representative **Date** **Witness Signature**

OFFICE USE ONLY

( ) ACCEPTED
( ) DENIED

_____ _____ _____

SIGNATURE **TITLE** **DATE**