Parent/Guardian Information: *(MOTHER'S INFORMATION –OR- GUARDIAN)*

Act#

First Name	MI	Last Name	Suf	Sex	DOB	SSN

Address:	Apt #	City	State	Zip

Home Phone:	Cell Phone:	e-mail address:

Employer:	*Employer Phone:*

Employer Address:	*City*	*State*	*Zip*

Parent/Guardian Information: *(FATHER'S INFORMATION –OR- GUARDIAN)*

First Name	MI	Last Name	Suf	Sex	DOB	SSN

Address:	Apt #	City	State	Zip

Home Phone:	Cell Phone:	Alternate Address:

Employer:	*Employer Phone:*

Employer Address:	*City*	*State*	*Zip*

*****IF YOU HAVE MORE THAN ONE CHILD PLEASE INDICATE ON THE REVERSE SIDE*****

Patient Information:

First Name	MI	Last Name	Suf	Sex	DOB	SSN

Address:	Apt #	City	State	Zip

Home Phone:	Race:	Ethnicity:	Language spoke in home:

Child Resides With: *Please circle one*

MOTHER FATHER BOTH PARENTS GUARDIAN OTHER:

Insurance Information:

Primary Insurance Company

Name: ____________________ Policy #: ____________________

Group #: ____________________ Relationship: ____________________

Subs. Name: ____________________ Subs. SSN#: ____________________

Subs. DOB: ____________

Secondary Insurance Company

Name: ____________________ Policy #: ____________________

Group #: ____________________ Relationship: ____________________

Subs. Name: ____________________ Subs. SSN#: ____________________

Subs. DOB: ____________

Tertiary Insurance Company

Name: ____________________ Policy #: ____________________

Group #: ____________________ Relationship: ____________________

Subs. Name: ____________________ Subs. SSN#: ____________________

Subs. DOB: ____________

Patient Information

Act#

First Name MI	Last Name Suf	Sex	DOB	SSN
Address: Apt #	City	State Zip		
Home Phone:	Race: Ethnicity: Language spoke in home:			
Child Resides With: *Please circle one* MOTHER FATHER BOTH PARENTS GUARDIAN OTHER:				

Patient Information

First Name MI	Last Name Suf	Sex	DOB	SSN
Address: Apt #	City	State Zip		
Home Phone:	Race: Ethnicity: Language spoke in home:			
Child Resides With: *Please circle one* MOTHER FATHER BOTH PARENTS GUARDIAN OTHER:				

Patient Information

First Name MI	Last Name Suf	Sex	DOB	SSN
Address: Apt #	City	State Zip		
Home Phone:	Race: Ethnicity: Language spoke in home:			
Child Resides With: *Please circle one* MOTHER FATHER BOTH PARENTS GUARDIAN OTHER:				

Are there any cultural/language/visual/hearing or religious factors that would affect the care given to this child?
If so, please list: ______________________________

Pharmacy Name, Address & Phone #: ______________________________

____

Please list any additional information:

____

____

Authorization to release information to insurance companies if needed:

Signature :______________________ Date: ______________ Witness:____________

OFFICE USE ONLY:

Entered By: ____________ Date: ____________
HIPAA Booklet Given? Y N _____ Welcome Letter Given? Y N ________

Pediatric Associates, LLC ☼ 1318 S. Main Rd. ☼ Vineland, NJ ☼ 08360 ☼ (856)691-8585 ☼ FAX: (856) 691-8489

******Please See Other Side******

form revised 5/12 dlc

Pediatric Associates, L.L.C.
1318 S. Main Road
Vineland, New Jersey
08360

I, ____, am parent or legal guardian of ___________________________________.

Other children who come to this practice who are also included in this consent:

- ______________________________ D.O.B ______________________
- ______________________________ D.O.B ______________________
- ______________________________ D.O.B ______________________
- ______________________________ D.O.B ______________________

In the event that I, or another parent or legal guardian, am unable to be present for my child(ren's) visit, the following people are authorized to bring the above named child(ren) to Pediatric Associates for treatment. This permission shall remain in force until I give written notification to Pediatric Associates.

Adults Name	Relationship to Child	Guardian Initials

___________________________________ ______________
Signature of Parent or Legal Guardian Date

******OVER. Please see other side******

Pediatric Associates, L.L.C.
1318 S. Main Road
Vineland, New Jersey
08360

Acknowledgment of Privacy Notice

By signing below, I hereby acknowledge the receipt of a copy of the Pediatric Associates Notice of Privacy Practices.
(HIPPA)

Date: ________________

Name: ________________________

Signature: ________________________

Relationship to Patient: ________________________

Please list the COMPLETE names and dates of birth of all children in your family, who come to this practice:

- ______________________________ D.O.B ______________________
- ______________________________ D.O.B ______________________
- ______________________________ D.O.B ______________________
- ______________________________ D.O.B ______________________
- ______________________________ D.O.B ______________________
- ______________________________ D.O.B ______________________
- ______________________________ D.O.B ______________________
- ______________________________ D.O.B ______________________

****Over. Please see other side****

Patient Name: ______________________________ **DOB:** _________________________

OFFICE POLICY FOR PATIENTS WITH INSURANCE COVERAGE

It is customary to pay for services when rendered unless other arrangements have been made in advance. In order to accommodate the needs and requests of our patients, we have enrolled in many insurance companies.

While we are pleased to be able to provide this service to you, it is not possible for us to keep track of all the individual policies, changes and updates of the plans. Each has different requirements regarding how often services may be rendered, and even more importantly, where those services may be performed. **It is mandatory that you, as the patient, know your policy.** Within the same insurance company the plans differ depending upon what type of contract your employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at each time of service, exactly what are those guidelines.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently order services (such as testing, lab work, hearing and vision screenings) that are not covered, our office or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

If your insurance changes or is not active for services to be billed and we are not clearly notified and documented, you will be responsible for all fees that have been incurred. If your insurance company violates its contract with our office, you will be responsible for all financial balances.

In the event we don't participate with your insurance company and we are able to bill them partial payment, you will be responsible for any balance left unpaid by your insurance.

Any costs incurred in the collection of monies owed will be the responsibility of the parent.

I have read and understand the office policy and agree to accept responsibility as requested. I authorize direct payment to Pediatric Associates.

I have received and/or read the **Notice of Privacy Practices** provided to me by Pediatric Associates. I agree to allow Pediatric Associates to share information with family pertaining to my care. If I disagree or wish to exclude anyone I will list below:

Release of Information to Insurance Company

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to your insurance carrier, your health information on this form may be shared with them. Your health information which any insurance carrier sees will be kept confidential by them. I also grant Pediatric Associates permission to view my child's prescription history from external sources.

This consent will stay in effect until we receive written notification from you.

I AGREE TO AND UNDERSTAND ALL CONTENTS ON THIS FORM. THE SIGNATURE BELOW IS FOR ALL ITEMS WITHIN.

SIGNATURE ______________________________ DATE ____________________