GREENWICH PEDIATRIC ASSOCIATES

Patient Information:

Last name: _____First name: _____ Middle Initial: _____

Nickname: _____ Date of Birth: _____Sex: Male / Female / Other _____

Sibling #1: _____ Sibling #2: _____

Sibling #3: _____ Sibling #4: _____

Address: _____Zip Code:_____

City: _____ State: _____

Children Live with: Mother Father Guardian

Home Phone #: (___) ____-_____

Parent #1
Name: _____ DOB: _____Cell # (___) ____-_____

Work Phone #: (___) ____-_____ Email address: _____

Parent #2
Name: _____ DOB: _____ Cell # (___) ____-_____

Work Phone #: (___) ____-_____ Email address: _____

Referred by: _____

Responsible Party Information:

Responsible Party Name: _____

Address: _____Zip Code:_____

City: _____ State: _____

Insurance Information:

Primary Insurance Company: _____Primary Insured: _____

ID #:_____ Group #: _____

Office Policy of Payment:

All professional services rendered are charged to the patient and are due at the time of service, unless arrangements have been specifically made in advance with the office. All accounts over 90 days will be charged an interest rate of 1.5 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. **Our office requires 24 hours notice for appointment cancellation and rescheduling. Failure to provide this notice will incur a cancellation fee.**

Insurance Policy:

You are responsible for all copays, consinsurance, deductibles, lapse in coverage or charges not covered by insurance. It is the parents'/patient's responsibility to be knowledgeable about their insurance coverage and limitations. Necessary forms will be completed to file for insurance carrier payments. 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 Greenwich Pediatric Associates 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 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 or if over 18 years of age, myself. 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-payments are due at the time of service and as part of the contract between me and my insurance carrier**. Failure to pay co-payments at the time of service, will result in an additional administrative fee.

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that Greenwich Pediatric Associates, LLC has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and disclosed, and how I can access this information.

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.

This authorization will remain in effect until revoked in writing by patient/parent.

Signed: _____Date:_____ Relationship: _____

In Case of Emergency, Please Contact:

Name: _____Phone Number: (___)____-_____Relationship: _____

Address: _____ Zip Code:_____

City: _____ State: _____

We appreciate the opportunity to serve you

Greenwich Pediatric Associates
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