valley pediatrics of greenwich

Today's Date: _____

Parent/Guardian Name: _____
DOB: _____
Cell: _____
Home: _____
Work: _____
Email: _____

Parent/Guardian Name: _____
DOB: _____
Cell: _____
Home: _____
Work: _____
Email: _____

Preferred Method of Contact: _____

Preferred Method of Contact: _____

Home Address:
_____
_____
_____

Billing Address: (If different than Home Address)
_____
_____
_____

Primary Insurance
Ins Company: _____
Policy #:_____
Group #:_____
Effective Date: _____
Subscriber: _____DOB: _____
Employer: _____

*If your insurance ID has individual suffix #'s for each member please provide above

All Children's Last Name: _____
Childs First Name: _____DOB_____Gender____INS#_____Suffix_____If any
Name: _____DOB_____Gender_____INS#_____Suffix_____If any
Name: _____DOB_____Gender_____INS#_____Suffix_____If any

In the case of an emergency, please contact (other than parents):

Name: _____
Phone Number: _____

Name: _____
Phone Number: _____

FINANCIAL AGREEMENT

I, the responsible party listed below, hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable co-payments and deductibles which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient which is not considered to be a covered service by third party insurers or payors.

Additionally, I understand that Valley Pediatrics of Greenwich requires 24hr change/cancellation notice for appointments. There will be a $50 charge for missed appointments if no notice is given.

Signature of Responsible Party Date

RELEASE STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS

TO THE PROVIDER

I, the undersigned responsible party, hereby authorize this office/its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I authorize the release and disclosure of any and all of my child's medical records to any other entity, including but not limited to, specialty physicians, hospitals, or other health care providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.

I authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled. I authorize this office and/or its employees to release, via fax machine or other encrypted methods, medical records which are needed in order to provide the patient with the most appropriate medical care.

I authorize and request that payment of any third party or insurance company benefits be made to this office for any services furnished to the patient. The signature below shall suffice for all insurance forms on a continuing basis.

Signature of Responsible Party Date

Consent for Treatment of Minor

I, _____, legal guardian

Give **the following adults** permission to make decisions regarding the necessary and/or routine treatment of my children including, but not limited to, examinations, injections, immunizations, and/or diagnostic procedures including X-rays or laboratory analysis. I understand that myself and those listed below will have the authority to authorize treatment. I also authorize treatment (except for immunization) or my teen (16 years or older) without requiring the presence of an adult. However, if my teen needs immunizations, and comes in alone, a parent/guardian must be available to phone for verbal consent.

(I.E. NANNY, BABYSITTER, GRANDPARENTS WITH PERMISSION TO MAKE DECISIONS)

Name	Phone	Relationship to Patient

I understand that any person bringing the patient in for treatment not listed above must have a letter of consent from me, or treatment may be refused or delayed. I understand that, in an emergency, efforts will be made to contact me prior to the rendering of medical treatment, but that medical treatment will not be withheld if I cannot be reached.

This authorization will remain in effect unless so designated in writing that such consent for treatment of minor is cancelled. I have read all the information on this sheet and have provided the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify Valley Pediatrics of any changes as to the health status of my children or the above information.

Completed by:	Date:
Signature:	

valleypediatrics of greenwich

PAUL E. JUAN, M.D.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients'Name(s):_____ _____

_____ _____

_____ _____

_____ _____

Relationship to patient(s):_____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the signature of the patient's legal guardian(s) on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initial:_____

Reason:

_____

_____