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

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, 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

Acknowledgement of Privacy Notice

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

Date: _____

Name: _____

Signature: _____
If completed this form from the website, do not sign this document until you come into the office for your appointment and receive the policy.

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 _____

*******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_____