Date: _____ _____ _____ _____ _____ _____ _____
verified/initials verified/initials verified/initials verified/initials verified/initials verified/initials

Patient Information:

	Last	First	Middle	Birthdate	Gender	Race	Child's Cell Phone
1.							
2.							
3.							
4.							
5.							
6.							

Guarantor (Parent Responsible for Payment)	Other Parent
Full Name _____	_____
Male or Female (circle one)	Male or Female (circle one)
Birthdate _____	_____
Address _____	_____
City, State, Zip _____	_____
Home Phone( ) _____	**( )** _____
Work Phone ( ) _____	**( )** _____
Cell Phone ( ) _____	**( )** _____
E-mail _____	_____
Social Security #_____	_____
Employer _____	_____
Occupation _____	_____

Person Child Lives with _____
Emergency Contact _____ **Relationship**_____
Emergency Contact Phone ( )_____ **Cell ( )** _____

Patient Confidential Communication Preference (Example: Automated Appointment Reminders)
Circle one Text Email Telephone Call

List the number or email _____

Whom may we thank for referring you to our office_____

Insurance Information:

Insurance card must be presented at each visit. It is the responsibility of the cardholder to provide us with current information and to contact the insurance company for benefit coverage information. Co-payments, co-insurance, deductibles and previous balances are due at the time of service.

Name of Insured _____

Relationship to patient ____ parent ____ step parent ____ grandparent ____ self

Other _____

Address of Insured_____

City, State, Zip_____

Insured Birthdate _____

Insurance ID # _____ Group # _____

Employer _____

Occupation _____

Authorization for Payment and Financial Responsibility (Please read and sign):

I agree to provide my insurance card at each visit, pay my co-pay/deductible and understand that fees for services rendered are my financial responsibilities. I understand that unpaid claims that are not paid by my insurance company within 45 days from the date of service will be transferred to patient responsibility and will be due upon receipt of the statement. I also understand that balances for items that my insurance company deems as "non-covered services" or "not medically necessary" are also my financial responsibility. I understand that if my account is transferred to an outside collection agency that I agree to pay all associated cost including the collection fee charged by the agency, applicable attorney fees and court costs. Furthermore, I understand that after my account balance is transferred to a collection agency that I agree to pay for services when seen and file my own insurance claims until all collection debts are paid in full. Green Hills Pediatric Associates charges $20.00 for a returned check. **A $50 missed appointment fee may be charged for well appointments that are missed or not cancelled less than 24 hours before the scheduled appointment time.**

Authorization to Release Medical Information and Consent to Treatment:

I authorize the release of any medical records in accordance with HIPAA guidelines, via the fax, e-mail, and/or the United Postal Service including the diagnosis, treatment or examination rendered to my child during the period of treatment for the processing of insurance claims, or to satisfy requirements of managed care organizations of which I am a member. I assign to the physician or physician's group all payments for the medical services rendered to my child. I authorize Green Hills Pediatric Associates to leave or send appointment reminder messages o voicemail, text or email. I also authorize Green Hills Pediatric Associates to utilize any e-mail address that I provide to them as a form of communication. I understand that if I request any change in this information that I am responsible for notifying this office in writing of such request**. I consent to treatment of my child by the physicians of Green Hills Pediatric Associates.**

Acknowledgement of Receipt of the Notice of Privacy Practice:

I acknowledge that I have received the Notice of Privacy Practices from Green Hills Pediatric Associates. This notice describes how this office may use and disclose my protected health information. I understand that I can obtain additional copies on the website at www.greenhillspeds.com **at any time.**

_____ _____

Signature of parent/guardian **Date**