160 Robbins Street
Waterbury, CT 06708
Phone: (203) 755-2999

One Pomperaug Office Park
Southbury, CT 06488
Fax: (203) 755-6782

(BOTH SIDES OF THIS FORM MUST BE COMPLETED IN ITS ENTIRETY)

Mother / Guardian Information *(for child(ren) listed below)* Email ______________ DATE: ________

Name ______________ Date of Birth ______________ Social Security # ______________

Address ______________ City ______________

State ______________ Zip ______________ Primary Phone ( ) ______________

Home Phone ( ) ______________ Cell Phone ( ) ______________ Work Phone ( ) ______________

Employer Name ______________ Occupation ______________

Father / Guardian Information *(for child(ren) listed below)* Email ______________

Name ______________ Date of Birth ______________ Social Security # ______________

Address ______________ City ______________

State ______________ Zip ______________ Primary Phone ( ) ______________

Home Phone ( ) ______________ Cell Phone ( ) ______________ Work Phone ( ) ______________

Employer Name ______________ Occupation ______________

Marital Status (circle): Married Single Widowed Separated IF DIVORCED: ☐ JOINT CUSTODY ☐ SOLE CUSTODY ☐ LEGAL DOCUMENTS PROVIDED

Patient Information

Primary Physician: ______________

Children's Legal Name Under 18 Yrs Old	Sex M/F	Date of Birth	Child lives with (Mother / Father / both)

RACE:
- ☐ WHITE OR CAUCASIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ HISPANIC OR LATINO
- ☐ ASIAN
- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ OTHER ______________
- ☐ PATIENT DECLINED TO PROVIDE INFORMATION

ETHNICITY:
- ☐ HISPANIC OR LATINO
- ☐ NOT HISPANIC OR LATINO

LANGUAGE:
- ☐ ENGLISH
- ☐ SPANISH
- ☐ POLISH
- ☐ FRENCH
- ☐ RUSSIAN
- ☐ TURKISH
- ☐ OTHER ______________

Emergency Contact (other than Parent)

Name ______________ Relationship To Patient ______________

Home Phone ( ) ______________ Work Phone ( ) ______________ Cell Phone ( ) ______________

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE COMPANY	MEMBERSHIP NUMBER	GROUP NUMBER	SUBSCRIBER NAME

CONSENT TO RELEASE

I hereby give Pediatric Associates of Conn., P.C. permission to speak with the following individual(s) regarding my child's personal medical information and/or permission to accompany child during visit:

Other: ______________ ______________
Patient or Responsible Party's Signature

______________ ______________ ______________
(example: grandparent, aunt, uncle, other) ***Relationship to Patient*** ***Date***

I understand fully that Pediatric Associates of Conn., P.C. does not accept assignment of all insurance companies. I understand that if I do not provide Pediatric Associates of Connecticut, P.C. with my correct insurance card in a timely manner, I will take full responsibility for any balance denied by my insurance company. If they do **not** accept assignment of my insurance company it is up to me to pay my bill in a timely manner. My insurance company will reimburse me for covered expenses. If I should become delinquent in the payment of my bills, I agree to pay reasonable attorney's fees incurred by Pediatric Associates of Conn., P.C. I also agree to pay a reasonable rate of interest (established by law) on all outstanding balances over 30 days if such interest shall be applied. I also authorize the disclosure of any information necessary to collect delinquent balances.

Release of Information & Assignment of Benefits: I authorize Pediatric Associates of Connecticut, P.C. to provide from its records any medical information requested by my insurance company, Medicaid, Champus, or other third party payers, including information related to substance abuse, HIV diagnosis and treatment, psychiatric treatment, and other confidential information, *(in connection with payment for incurred charges for the above listed patients.)* I also authorize the release of information from the medical record to any utilization and/or quality review organization affiliated with my insurer for use in utilization management. I also authorize the disclosure of any information necessary to collect delinquent balances.

Signature ______________ Date ______________

PLEASE SEE REVERSE SIDE

Authorization for Treatment and Release of Information

_____Initial I ____ authorize Pediatric Associates of Conn. to contact me by telephone with medical information pertaining to my child(ren)'s care. If I am unavailable, this authorization gives Pediatric Associates of Conn. permission to leave this information either on my answering machine or with a member of my household.

_____Initial I authorize Pediatric Associates of Conn. or whomever they designate to evaluate and treat my above named child and to release to my insurance company any information acquired in the course of my child's examination or treatment, and to receive all payments for such examination or treatment. PAC has my permission to release any diagnostic studies, report, etc. to a specialist involved in caring for my child.

_____Initial I understand that all health care decisions, including immunization authorization, must be made by a legal guardian or parent.

_____Initial A parent / guardian / or authorized care giver is to be present at every visit. If someone else is bringing your child, we will need prior written authorization that includes authorization for treatment, your contact information, and insurance and co-pay payment authorization for this visit. (Refer to front of form)

_____Initial I understand that in order to insure our patient's safety and security we will be taking a picture of your child(ren) at their well visits. The picture is instantly imported into their electronic health record as a form of visual identification. This photo will ONLY be used for the use of Pediatric Associates to insure we are providing medical service to the correct patient. Patient's identity is verified through photo ID and birthdate.

Payment Policies

_____Initial Insurance information: Insurance card(s) must be presented at the time of service. A copy of your insurance card(s) will be made for your file. It is your responsibility to provide updated insurance information at the time of service. If the insurance card(s) is not presented at the time of service, the charges are your responsibility until a copy of the insurance card(s) is received. In order for services to be billed to your insurance company, a copy of the insurance card(s) must be received within 10 days from the date of service.

_____Initial Account Balances: When insurance information is received *after* the timely filing requirements of your insurance company, the charges for those services are your responsibility. You are responsible for payment of services unpaid by your insurance company and for timely payment of your account. PAC reserves the right to reschedule or deny future appointments for delinquent accounts.

_____Initial Co-payments: are expected to be paid at the time service is rendered.

_____Initial Self pay: Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Please ask about the Vaccine for Children program.

_____Initial Divorce situations: the parent bringing the child in for care is responsible for payment of co-payments. Both parents are responsible for payment on unpaid balances, regardless of divorce decree. If payment issues exist, they must be resolved between the parents.

_____Initial Referrals: If your plan requires referrals for specialty care recommended by your primary care physician, it is your responsibility to obtain information regarding these requirements and contact the referral specialist at this office to request a referral to be processed *prior* to the specialty appointment.

_____Initial No shows: A $25 no show fee will be assessed for all visits not previously cancelled.

Acknowledgement of Receipt of Notice of Privacy Practices and Form Policy

_____Initial I acknowledge that I have received the Notice of Privacy Practices, which explains how my health information will be handled in various situations.

_____Initial I have received PAC Form Policy

My signature below indicates I am the legal guardian for the patient(s) listed above, that I have provided accurate information to the best of my knowledge and I understand and agree to the provisions above.

Signature of Parent / Legal Guardian______________________________________ Date ________________

Please always notify us of any changes to the above information