Surprise Pediatrics – Patient Information

Patient Name: _____ **Sex: M F** **Date of Birth:** _____
First Name **Middle Initial** **Last Name**

MOTHER (check one) ☐**Biological** ☐**Step** ☐**Foster** ☐**Other:**_____

Name: _____ DOB: _____ SS#: _____-_____-_____
First Middle Initial Last
Address: _____ City/State/Zip:_____
Home Phone :(_____) _____ - _____ Cell Phone :(_____) _____ - _____
Employer: _____ Work Phone:(_____) _____ - _____
Email:_____ **Guarantor Responsible for the bill? Yes No**

FATHER (check one) ☐**Biological** ☐**Step** ☐**Foster** ☐**Other:**_____

Name:_____ DOB:_____ SS#: _____-_____-_____
First Middle Initial Last
Address: _____ City/State/Zip:_____
Home Phone :(_____) _____ - _____ Cell Phone :(_____) _____ - _____
Employer: _____ Work Phone :(_____) _____ - _____
Email:_____ **Guarantor Responsible for the bill? Yes No**

Primary Insurance:_____ **Address:**_____
Identification # _____ **Group #:** _____
Subscriber:_____ **DOB:** _____ **SS#:** _____- _____ - _____
Employer: _____ **Relationship to child: mother father other:** _____
*****IF YOU HAVE SECONDARY INSURANCE, please complete Secondary Insurance form*****

The following people have my permission to authorize medical treatment if we, the parents/legal guardians, are not available to give consent. I understand that it is our responsibility to notify Surprise Pediatrics in writing of any changes to this list.

Name _____ **Name** _____
DOB: _____ **Phone** _____ **DOB:** _____ **Phone** _____
Relationship to child _____ **Relationship to child** _____

Initials: _____ **I have reviewed the posted Notice of Privacy Practices for Surprise Pediatrics as part of the Health Insurance Portability and Accountability Act (HIPAA).**

Initials: _____ **I have received a copy of the Surprise Pediatrics Financial and Office Policies (Sept 2014). I agree to abide by all of its terms and conditions knowing that failure to comply may result in discharge from the practice.**

Initials: _____ **I am responsible for knowing my insurance benefits and updating all information with my insurance(s) as needed.**
I am aware that a Well / Sick combined Medical Diagnosis may occur resulting in treatment and additional charges such as Labs, Prescriptions or additional testing. These additional charges may or may not be covered by my Insurance or may be applied to my Deductable, Co-Insurance or out of pocket copay.

I hereby confirm that the above information is complete and accurate, and that I am the responsible party for this minor. I hereby authorize Surprise Pediatrics to examine and treat my child when necessary. I also authorize the release of protected health information, acquired in the course of examination, to carry out treatment, payment, and the healthcare operations of my child. I authorize my insurance benefits to be paid directly to Surprise Pediatrics. I understand that I am responsible for any unpaid balance for services rendered but not covered by my insurance policy (ies). If my account is referred for collection, I agree to pay the balance due, collection fee of 40%, all attorneys' fees, and any other associated costs incurred.

Parent/Legal Guardian Printed Name:_____ **Relationship to child:**_____

Parent/Legal Guardian Signature:_____ **Date:**_____

UPDATED (STAMP) _____
NO CHANGES (PARENT INITIAL) _____