Shifa Pediatric Clinic, PLLC

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PATIENT INFORMATION

Today's Date ____/____/____

Child's Legal Name _____

Nickname (if any)_____

SS#_____-_____-_____ **Sex**_____

Age_____ **Date of Birth** _____/_____/_____

Names of your other children who are patients here:
1._____

2._____

Parent/Legal Guardian Responsible for Account Information Mother/Legal Guardian's Name

_____

Date of Birth_____/_____/_____ SS#_____-____-_____

Home Address_____

_____
City State Zip

Home Phone (_____)_____-_____
Cell Phone (_____)_____-_____
Work Phone (_____)_____-_____ Ext____
Place of Employment_____

Father/Legal Guardian's Name

_____

Date of Birth_____/_____/_____ SS#_____-____-_____

Home Address_____

_____
City State Zip

Home Phone (_____)_____-_____
Cell Phone (_____)_____-_____
Work Phone (_____)_____-_____ Ext____
Place of Employment_____

Emergency Contact's Name (other than the Parent's)

_____

Home Phone (_____)_____-_____
Cell Phone (_____)_____-_____

If parents are divorced who has legal custody of child?

_____

How did you hear about our practice?

_____

Who, if anyone other than the responsible party, has permission to be involved in your child's medical treatment including bringing them in for visits?

_____
Name Relationship

_____
Name Relationship

Insurance Assignment and Releases

I, the undersigned hereby assign, transfer and set over to Shifa Pediatric Clinic PLLC all my rights, title and interest in and to medical and/or surgical benefit payments to which I am entitled resulting from the medical and/or surgical services performed for me by Shifa Pediatric Clinic PLLC and I direct my insurance company to pay any and all such entitlements directly to Shifa Pediatric Clinic PLLC.

_____
Parent or Legal Guardian Responsible for account.

I authorize Shifa Pediatric Clinic PLLC to render medical care to my child. I understand that all co-pays and deductibles are to be paid at the time of service. In the event that my account becomes delinquent and must be turned over to a collection agency or attorney, I understand that any and all of my child's future appointments will be canceled and I cannot schedule any further appointments until the account is resolved, and I agree to pay any and all costs of collection including attorney's fees. In the event that my child is referred to a specialist or hospitalized, I authorize the release of any medical information necessary to process an insurance claim. I understand that my insurance policy is a contract between myself and my insurance company and that I am financially responsible for charges not covered by the policy including any administrative fees due to late, cancellation, rescheduling of an appointment, missing an appointment altogether, and any fees for medical records. I will assist in the collection of my insurance benefit should there be any delay in payment.

_____
Parent or Legal Guardian Responsible for Account.

I have received the attached sheet "Shifa Pediatric Clinic PLLC Financial Policy"

_____
Parent or Legal Guardian Responsible for Account

I have received the attached "Notice of Privacy Policies / HIPAA", detailing how my information may be used and disclosed as permitted under federal and state law. I further understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to these restrictions.

_____
Parent or Legal Guardian Responsible for Account