ABC Pediatrics PC

4288 3 Mile Rd NW Suite 1 Walker, MI 49534 Phone (616) 458-3677
3050 Ivanrest SW Grandville, MI 49418

PLEASE LIST ALL CHILDREN WHO WILL BE PATIENTS AT ABC PEDIATRICS PC BELOW:

1. Name ________________________________ **Nickname** _____________ **Date of Birth** __________ **Male / Female (circle)**
(Last) (First) (M.I.)

Social Security # ____________________ **Primary Physician** _________________________ **Medicaid ID #:** ____________

Race/Ethnicity ____________________________________ **Preferred Language** _________________________________

2. Name ________________________________ **Nickname** _____________ **Date of Birth** __________ **Male / Female (circle)**
(Last) (First) (M.I.)

Social Security # ____________________ **Primary Physician** _________________________ **Medicaid ID #:** ____________

Race/Ethnicity ____________________________________ **Preferred Language** _________________________________

3. Name ________________________________ **Nickname** _____________ **Date of Birth** __________ **Male / Female (circle)**
(Last) (First) (M.I.)

Social Security # ____________________ **Primary Physician** _________________________ **Medicaid ID #:** ____________

Race/Ethnicity ____________________________________ **Preferred Language** _________________________________

4. Name ________________________________ **Nickname** _____________ **Date of Birth** __________ **Male / Female (circle)**
(Last) (First) (M.I.)

Social Security # ____________________ **Primary Physician** _________________________ **Medicaid ID #:** ____________

Race/Ethnicity ____________________________________ **Preferred Language** _________________________________

5. Name ________________________________ **Nickname** _____________ **Date of Birth** __________ **Male / Female (circle)**
(Last) (First) (M.I.)

Social Security # ____________________ **Primary Physician** _________________________ **Medicaid ID #:** ____________

Race/Ethnicity ____________________________________ **Preferred Language** _________________________________

****If the parents are separated, which household do/does the child/children reside at?** ________________________

PARENT OR GUARDIAN INFORMATION

FATHER:

Name: _____________________________ Date of Birth ___________ Marital Status _____ **E-Mail** ___________________
(Last) (First) (M.I.)

Address: ____ Social Security #: _____________ Employer _______________
(Street Address) City / State / Zip

Primary Phone: (___) ______________ Alternative Phone: (___) ______________ Alternative #2 Phone: (___) ______________

MOTHER:

Name: _____________________________ Date of Birth ___________ Marital Status _____ **E-Mail** ___________________
(Last) (First) (M.I.)

Address: ____ Social Security #: _____________ Employer _______________
(Street Address) City / State / Zip

Primary Phone: (___) ______________ Alternative Phone: (___) ______________ Alternative #2 Phone: (___) ______________

****OVER****

IF INSURANCE IS THROUGH SOMEONE OTHER THAN THE CHILD'S FATHER / MOTHER, PLEASE COMPLETE:

Insurance Card Holder's Information

Relationship to Patient______________________________

Name: ________________________________ Date of Birth ____________ Marital Status ______ E-Mail ____________________
(Last) (First) (M.I.)

Address: ____ Social Security #: ________________ Employer ________________
(Street Address) City / State / Zip

Home Phone: (___) _________________ Work / Other Phone: (___) ___________________ Cell Phone: (___) _____________

Primary Insurance Carrier _______________________________ Subscriber _____________________________ Date of Birth _______________

Policy No__________________________________ Group No _________________ Phone No (_____)____________________

Secondary Insurance Carrier _______________________________ Subscriber _____________________________ Date of Birth _____________

Policy No__________________________________ Group No _________________ Phone No (_____)____________________

I understand according to the State of Michigan, Department of Health, Act 488 of 1988 that if a health care professional in this practice sustains a cutaneous, mucous membrane or open wound exposure to blood or other body fluids from my family member that a HIV and Hepatitis-B (HBV) blood test will be performed.

Signature ____ **Date**______________________________

I authorize payment of medical benefits by the insured directly to ABC Pediatrics PC. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or materials provided to my family member and for any yearly deductible or co-payment amounts. I agree to pay all services within 30 days unless a payment plan is negotiated in advance. I authorize ABC Pediatrics PC to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

Signature ____ **Date**______________________________

Authorization For Specific Confidential Communications

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:
(List anyone *other than* parents)

Name: _______________________________________ Relationship to Patient ________________________
Name: _______________________________________ Relationship to Patient ________________________

Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:

- o Medical Care / Treatment: **Yes** ___ **No** ___ **Level of Information** ____
- o Billing Information **Yes** ____ **No** ____
- o Pick up PHI: (such as prescriptions, billing statements, labs etc.) **Yes** ___ **No** ___
- o Other (specify in detail – such as date of service, type of service, level of detail to be released, origin of information etc.)
  ____
  ____

This authorization shall be in force and effect and does not expire until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: ABC Pediatrics 4288 - 3 Mile Road NW Walker, MI 49534. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____ Date __________________________________
Patient / Parent / Guardian Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of this office's Notice of privacy Practice Form.

____ **Date** ___________________________________
Patient / Parent's / Guardian's Signature