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 ______________________	______________________
Employer ______________________	______________________
Occupation ______________________	______________________

Person Child Lives with ____

Emergency Contact ______________________ Relationship______________________

Emergency Contact Phone ( )__________________ Cell ( ) ______________________

Whom may we thank for referring you to our office?______________________________

Authorization for Confidential Communication:

Patient Confidential Communication Preference for Automated Appointment Reminders
Circle one Text Email Telephone Call

Number or email ____

I authorize Green Hills Pediatric Associates (GHPA) to utilize the patient confidential communication preferences that I provide to them as a form of communication. I authorize GHPA to leave or send appointment reminder messages on voicemail, text or email. I understand that if I want to change this information, that I am responsible for notifying the office. I further understand that in order to revoke my consent to be contacted, I must notify GHPA.

Authorization for Payment and Financial Responsibility:

I agree to provide my insurance card at each visit and pay my co-pay/deductible. I understand that fees for services rendered are my financial responsibility. I understand that claims 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, I agree to pay all associated costs including the collection fee charged by the agency, applicable attorney fees and court costs. Furthermore, after my account balance is transferred to a collection agency, I agree to pay for services when seen and file my own insurance claims until all collection debts are paid in full. GHPA charges $20.00 for a returned check. A $50 missed appointment fee may be charged for well appointments that are missed or cancelled less than 24 hours before the scheduled appointment time.

Consent for Contact Related to Bill Collection or Debt Collection

I acknowledge and agree that Green Hills Pediatric Associates (GHPA), including any bill collection or debt collection companies, may contact me by telephone or by text message to any telephone number I provide to GHPA, or any other telephone number associated with my account, including wireless telephone numbers, which I understand could result in charges. I further agree that GHPA may use any method of contact to any of these telephone numbers, including prerecorded or artificial voice messages, text messages and automated dialing devices. You may also contact me via electronic mail using any email address I have provided to you for use. I acknowledge that contact information provided to you is private to me and I take sole responsibility for maintaining the privacy of any of the information I provide to you. I further understand that in order to revoke my consent to be contacted, I must notify GHPA.

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 consent to treatment of my child by the physicians of GHPA.

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**