

KIDS TIME PEDIATRICS



PATIENT INFORMATION

Patient Name: Last _____ First _____ Middle _____ Male Female
Home Phone: _____

Date of Birth:(Month/Day/Year): ____/____/____

Patient's Address: Street Number and Name _____ Apt. # _____ City _____ State _____ Zipcode _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship: _____ Phone No. _____

PARENT/GUARDIAN INFORMATION

Mother's Information:

Name: _____

Social Security Number: _____ - _____ - _____

Date of Birth: _____

Email: _____ Home Phone: _____

Wk Phone: _____ Cell Phone: _____

Father's Information:

Name: _____

Social Security Number: _____ - _____ - _____

Date of Birth: _____

Email: _____ Home Phone: _____

Wk Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

Name of Insurance Company: _____

Name of the insured (the person insurance is through): _____

Relationship to patient: _____ Employer: _____ Phone: _____

Patient's Insurance ID No. _____ Insurance Group No. _____ Insured Date of Birth _____

Do you have any other Insurance? Yes No If yes, what is the Name of Insurance Company: _____

Person Insurance is through: _____ Insurance ID No. _____ Insurance Group No. _____

FINANCIAL RESPONSIBILITY

I agree that I am financially responsible for all charges incurred on this account and I assign all insurance benefits to KIDS TIME PEDIATRICS. I am responsible for any portion of the account not paid in full by insurance. Please note that payment of any co-pay, deductibles or visit amounts will be collected at the time of service. IT IS UNDERSTOOD THAT THERE MAY BE ADDITIONAL CHARGES FOR LABORATORY TESTS AND X-RAY TESTS PERFORMED BY PROVIDERS OR ORGANIZATIONS OTHER THAN KIDS TIME PEDIATRICS THAT WILL BE BILLED SEPARATELY.

KIDS TIME PEDIATRICS is offered as a service of your primary pediatrician. Physicians in the practice may be owners of the local KIDS TIME PEDIATRICS after-hours office. You are not required to utilize the KIDS TIME PEDIATRICS facility for any services. Similar services may be available elsewhere in the community. An alternative referral can be provided upon your request.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize KIDS TIME PEDIATRICS to disclose all or any part of the patient's medical record and/or clinic charges to any person or corporation (i) which is or may be liable or under contract to KIDS TIME PEDIATRICS for reimbursement, subrogation and/or direct recovery and coordination of benefits for this and all future claims including but not limited to hospital/medical service companies, worker's compensation carriers, welfare funds, governmental agencies and (ii) any health care provider for continued patient care. KIDS TIME PEDIATRICS may also disclose on an anonymous basis any information concerning the patient's case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. Except, as above, KIDS TIME PEDIATRICS will require the patient's, or in the case of a minor child, a natural parent or legal guardian's, written consent to release information about the patient. I also agree that in all instances, the original medical records remain the property of KIDS TIME PEDIATRICS.

PATIENT ACKNOWLEDGEMENT:

The KIDS TIME PEDIATRIC Notice of Privacy Practices provides information about the privacy right of our patients; and how we may use and disclose protected health information (PHI) about our patients. Federal regulation requires that we give our patients or their authorized representative the opportunity to review our Notice before signing this acknowledgement. A copy of our Notice will be made available to you at your request.

If you have any questions about your rights or our privacy practices please send a letter to the following address. A response will be sent within seven (7) business days.

Privacy Officer
Kids Time Pediatrics, LLC
PO Box 509
Madison, GA 30650

By signing below, you acknowledge that you have been provided with notice of the Privacy Practices, Release of Information and your financial responsibility.

Signature of Patient or Authorized Patient Representative: _____ Date: _____

Printed Name of Authorized Patient Representative: _____