PATIENT REGISTRATION

CHILD (REN)

Patient | Sex (M/F) | Date of Birth | Social Security #

Patient | Sex (M/F) | Date of Birth | Social Security #

Patient | Sex (M/F) | Date of Birth | Social Security #

Address | City | State | Zip | Preferred Phone #

Billing Address (if different from patient's address) | City | State | Zip

Parent (Guardian)

Full Name | Date of Birth | Social Security # | Marital Status

Employer | Business Phone # | Cellphone #

Email Address

Parent (Guardian)

Full Name | Date of Birth | Social Security # | Marital Status

Mother's Maiden Name | Email Address

Employer | Business Phone # | Cell phone #

In case of Emergency, who should we contact (Please provide a name other than a parent)

Name | Relation | Telephone #

Insurance Company | ID # | Group #

Subscriber | Subscriber's Relationship to Patient | Effective Date

Secondary Insurance | ID # | Group #

Subscriber | Subscriber's Relationship to Patient | Effective Date

PHARMACY PREFERENCES

Day Pharmacy | Phone/Fax/Email

AUTHORIZATION FOR TREATMENT AND AUTHORIZATION FOR ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned hereby authorize the Doctors and staff of Palisades Pediatrics, LLP to treat the medical condition(s) of my child(ren), and further authorize my signature below for use on any claims submitted on our behalf for such services. I hereby irrevocably accept financial responsibility for all medical and related services received while under medical care, and assign all insurance benefits otherwise payable by the insurance company for said services. I, the undersigned, understand that I am financially responsible for any and all charges not covered by insurance, and further understand that payment of co-payments and/or deductibles for services received are due at the time that services are rendered. Accounts that have balances past 90 days may be turned over to a collection agency for payment on the account. If turned over to collections, I understand that I will be responsible for collection agency fees and court costs if brought to trial.

No Changes: _____
No Changes: _____
No Changes: _____
No Changes: _____

_____
Signature of Parent or Guardian

_____
Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice and request a copy. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

Patient Name: _____

Date of Birth: _____

I, _____, have read a copy of Palisades Pediatrics, LLP's
Patient or Legal Guardian

Notice of Privacy Practices. I understand the policies that have been outlined in the

Notice of Privacy Practices and that a copy will be made available to me upon request.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Relationship to Patient

PARENT/ LEGAL GUARDIAN PROXY FORM

Please fill out this form if you would like to authorize anyone other than the patient's legal guardian(s) to consent to evaluation and treatment by the physicians of Palisades Pediatrics, LLP

Patient Information

Print Name:_____
Date of Birth:_____
Medical Record Number (if known):_____

I have designated the following person(s) to be my child's representative for the purpose of receiving my child's protected health information and for medical evaluation and treatment at Palisades Pediatrics, LLP:

Representative Information (legal guardian(s) do not need to be listed)

Print Name:_____ DOB:_____
Relationship to Patient:_____

Print Name:_____ DOB:_____
Relationship to Patient:_____

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

Witness Name:_____
Witness Signature:_____ Date:_____

PATIENT REPRESENTATIVE FORM

Please fill out this form if you would like to authorize anyone other than the patient's legal guardian(s) to receive confidential health information over the phone/fax pertaining to treatment and payment for services by the physicians of Palisades Pediatrics, LLP

Patient Information

Print Name:_____
Date of Birth:_____
Medical Record Number (if known):_____

I have designated the following person(s) to be my/ my child's representative for the purpose of receiving my/ my child's protected health information:

Representative Information (legal guardian(s) do not need to be listed)

Print Name:_____ DOB:_____
Relationship to Patient:_____

Print Name:_____ DOB:_____
Relationship to Patient:_____

Patient/ Legal Guardian Name:_____
Patient/ Legal Guardian Signature:_____ Date:_____

Witness Name:_____
Witness Signature:_____ Date:_____

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize my child(ren)'s **previous pediatrician** :

Name: _____

Address: _____

_____

Telephone #: _____ Fax #: _____

to disclose certain protected health information (PHI) about me/ my child(ren):

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

to **Palisades Pediatrics, LLP at 236 North Main Street New City, NY 10956/ O# (845) 708-0400/ F# 0401**

This authorization permits Palisades Pediatrics, LLP to obtain the following individually identifiable health information about me/ my child(ren) (specifically describe the information to be used or disclosed, such as dates(s) of service, type of services, level of detail to be released, origin of information, etc):

_____.

The information will be used or disclosed for the following purpose:

_____.

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from Palisades Pediatrics, LLP. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at 236 North Main Street New City, New York 10956.

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Print Name of Patient or Legal Guardian — Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION IF REQUESTED

PROVIDER NAME: Palisades Pediatrics, LLP
236 North Main Street
New City, NY 10956

HEALTH CARE PROVIDER: A record must be kept in the healthcare provider's office that reflects the status of all children up to their 19th birthday who receive immunization through the NY VFC program. The record may be completed by the parent, guardian or individual of record, or healthcare provider. The same record may be used for all subsequent visits as long as their child's status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

PATIENT INFORMATION: Child/Patient Date of Birth: _____/_____/_____
MM DD YY

_____ _____ _____
Child/Patient Last Name First Name M.I

_____ _____ _____
Parent/Guardian's Last Name First Name M.I

Date of Screening _____/_____/_____
MM DD YY

Please circle the category that shows the child's eligibility (up to their 19th birthday) to receive publicly purchased vaccine in New York. The child is:

Please circle **one** of the following:

1. Medicaid/Medicaid managed care enrolled
2. Not insured/ No insurance
3. American Indian/ Alaskan Native
4. Underinsured and not eligible under 1, 2, or 3 above
5. Not eligible (insurance covers immunizations)

New York State Department of Health
Immunization Program
New York Vaccines for Children Program