

Pediatric Surgeons of West Michigan, P.C.

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YOUR CHILD

Full legal name _____

Nickname _____ Sex _____

Birthdate _____ Age _____

Home Address _____

City/State/Zip _____

Child's Social Security # _____

Telephone # () _____

MOTHER or _____ Guardian _____ Stepmother

Name _____

Home # _____

Cell # _____

Work # _____

Employer _____

Address (if different) _____

FATHER or _____ Guardian _____ Stepfather

Name _____

Home # _____

Cell # _____

Work # _____

Employer _____

Address (if different) _____

Are you the legal guardian for the patient? Yes No

If no, do you have written authorization from guardian for us to see &/or treat the patient? _____

Do you speak English Yes No

If no, what language do you speak? _____

PEDIATRICIAN OR FAMILY DOCTOR

Name _____ MD or DO

Practice Name _____

City _____ Phone # _____

EMERGENCY CONTACT (other than the parents)

Name(s) _____

Relationship to patient _____

Home # _____

Work # _____

INSURANCE COVERAGE

Primary Insurance Name _____

Subscriber's Full Name _____

Relationship to patient _____

Subscriber's SS # _____ DOB _____

Give us your card to copy

Secondary Insurance Name: _____

Subscriber's Full Name _____

Relationship to patient _____

Subscribers SS # _____ DOB _____

Give us your card to copy

Other insurance information pertinent to your child _____

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option which you prefer:

_____ Cash

_____ Personal check

_____ Credit Card _____ Visa _____ MC

_____ I wish to discuss the office's payment policy.

AUTHORIZATION AND RELEASE (Please read the following and sign below)

All professional services rendered to the patient are charged to the above indicated responsible parent. Necessary forms will be completed to help expedite insurance carrier payments, however, the parent is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. With my signature, I authorize Pediatric Surgeons of West Michigan, P.C., to furnish &/or receive information to or from any referral physician, facility or insurance carrier concerning the patient's illness and/or treatment. I hereby assign to the physician all payments for medical services rendered to the patient. I understand that I am responsible for any amount not covered by insurance.

DATE: _____ SIGNATURE _____

**ACKNOWLEDGMENT 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 Practices Form.

WITNESSES:

Parent/Guardian Signature

Date

Documentation of Failure to Obtain Signed Acknowledgment

On _____, 20____, _____ presented this Acknowledgment of Receipt of Notice of Privacy Practices Form to _____ (the "Patient"). The Patient refused to provide a signature when requested.

Whom may we discuss your child's care with?

Mother _____ Father _____ Other _____ Name: _____

Can we call your home phone number regarding your child's care? Yes ___ No ___

What information may we leave on your answering machine or voice mail?

Nothing _____ Everything _____ Other _____

Appointment reminder _____ Surgery information _____ Prescription information _____