PARK STREET PEDIATRICS, LLC

7 Park Street · Norwalk, Connecticut 06851 - Phone (203) 840-7566 · Fax (203) 840-7569

*** CURRENT INFORMATION SHEETS ARE REQUIRED **YEARLY BY YOUR INSURANCE COMPANY**

CHILD(REN)'S INFORMATION

NAMES SHOULD BE EXACTLY AS PRINTED ON INSURANCE CARD

Name: (First) (MI) (Last)	Date of Birth:	Gender:	Social Security #:
Name: (First) (MI) (Last)	Date of Birth	Gender	Social Security #
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Name: (First) (MI) (Last)	Date of Birth	Gender	Social Security #
Name: (First) (MI) (Last)	Date of Birth	Gender	Social Security #

MOTHER'S INFORMATION

☐ CHILD(REN) RESIDE WITH MOTHER

Name: (First) (MI) (Last)	Date of Birth:	Marital Status:	Social Security #:
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	E-Mail: / Employer:

FATHER'S INFORMATION

☐ CHILD(REN) RESIDE WITH FATHER

Name: (First) (MI) (Last)	Date of Birth:	Marital Status:	Social Security #:
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	E-Mail: / Employer:

EMERGENCY CONTACT INFORMATION - (SOMEONE OTHER THAN PARENTS)

Name: (First) (MI) (Last)	Relationship To Child:
Home Phone:	Work Phone: / Cell Phone:

INSURANCE INFORMATION

CARRIER OF INSURANCE: ☐ MOTHER ☐FATHER ☐ OTHER (IF OTHER, PLEASE FILL IN BELOW)

Insurance Company Name:	Identification # / Group #:	Effective Start Date:
Subscriber Name:	Subscriber SS#: / Subscriber Date of Birth:	Relationship to Child:
Address:	City: / State:	Zip:
Home Phone:	Work Phone: / Cell Phone: / E-Mail:	Employer Name:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

☐ I hereby acknowledge that I received a copy of Park Street Pediatrics Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted on their web site, and I may request a copy of any amended notices at each appointment.

☐ I hereby refuse receipt of Privacy Practices from Park Street Pediatrics.

I AGREE TO THE ASSIGNMENT OR FINANCIAL RESPONSIBILITIES SHOWN BELOW AND HIPAA PRIVACY PRACTICES ABOVE

I authorize Park Street Pediatrics, LLC to treat my child(ren) and the release of medical information as necessary for the completion of insurance, school & camp forms. I authorize payment directly to Park Street Pediatrics, LLC for any and all medical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all charges whether or not paid by said insurance and that I am financially responsible for all co-pays, deductibles and any charges not covered under my insurance benefits. I also understand I am responsible for advising Park Street Pediatrics, LLC of any changes to my insurance. If I do not have insurance coverage, I understand I am responsible for payment in full. Payment of co-pays are due on the date of service. Failure to pay a co-pay at time of servicewill result in an additional billing charge of $10.00. Failure to provide 24 hours notice, excluding weekends/holidays, for cancellation of any physical appointment will result i $50.00 charge. It is understood that if my account is turned over to a collections agency, I will be responsible for any collection costs which are incurred. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is to be considered as valid as the original.

Signed (Adult Responsible for Payment):	Print Name:	Date: