Patient Information Form

Child's Name: _____ **Gender**: Male Female
First *Last* *MI*

Date of Birth: _____/_____/_____ **Preferred Language**: _____

Race: *American Indian or Alaska Native – Asian – Black or African American – Pacific Islander – White – Prefer not to Answer*

Ethnicity: *Hispanic or Latino – Not Hispanic or Latino – Prefer not to Answer* **Gestational Age at Birth:** _____weeks ___days

Primary Insurance: _____ **Policy #:** _____

Secondary Insurance: _____ **Policy #:** _____

Pharmacy: (Name, city & street) _____

Patient lives with: (Name & Relationship) **(If applicable, list both parents, foster parents, grandparents, etc.)**		**Person responsible for billing/Insurance: (Name & Relationship)(Fill in this section if different from who child lives with)**	
Name: **DOB:** **Name:** **DOB:**		**Name:** **DOB:**	
Address, city, zip:		Address, city, zip:	
CELL #	WORK/HOME #	CELL #	SSN#
EMAIL		EMAIL	

Emergency Contact: (Name & Relationship)	**Other Contact: (Name & Relationship)(Other parent, etc)**
CELL-WORK-HOME # (circle one)	CELL-WORK-HOME # (circle one)

Please initial and sign at the bottom:

Insurance Authorization and Assignment

_____ **Authorization and Assignment of Benefits:** I hereby give permission to Kent Pediatrics, LLC and its employees, agents, and medical providers to release medical information to health plans, health organizations, governmental agencies, and other entities charged with fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payment of the medical benefits otherwise payable to me to be directed to Kent Pediatrics, LLC. I consent to have any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of any charges for the medical services provided. I understand that any or all of my medical information may be electronically submitted to any or all treating providers, hospitals, and/or health care entities. I permit a copy of this authorization to be used in place of the original.

_____ **Financial Policy Acknowledgement:** I hereby acknowledge that I have received and reviewed the FINANCIAL POLICY of Kent Pediatrics, LLC. I understand that it is my responsibility to provide Kent Pediatrics, LLC with my current demographic, insurance, and medical information.

_____ **HIPAA Privacy Acknowledgement:** I hereby acknowledge that I have received and reviewed the NOTICE OF PRIVACY PRACTICES from Kent Pediatrics, LLC.

Patient or Guardian Signature:_____ **Relationship:** _____ **Date:** _____

Patient Consent for Use and Disclosure of Protected Health Information

The individual whose signature appears below hereby attests to the following statements:

With my consent, KENT PEDIATRICS, LLC, may use and disclose Protected Health Information (**PHI**) about my child to carry out Treatment, Payment and healthcare Operations (**TPO**). (Please refer to KENT PEDIATRICS, LLC "Notice of Privacy Practices" for a more complete description of such uses and disclosures.)

With my consent, KENT PEDIATRICS, LLC, may disclose my child's PHI to the following individuals (family, relatives, or friends) who may assist in the care of my child:

Name	Relationship	Cell-Work-Home #: (circle one)

(Please indicate name, contact numbers, and relationship of individuals to whom KENT PEDIATRICS, LLC, may release PHI)

I have the right to review the Notice of Privacy Practices prior to signing this consent. KENT PEDIATRICS, LLC, reserves the right to revise its Notice of Privacy Practices at anytime. A written copy of our Notice of Privacy Practices may be obtained by forwarding a written request to our office.

CONSENT FOR CALLS TO HOME
With my consent, KENT PEDIATRICS, LLC, LLC may call my home or other designated location and leave message on my voice mail or with a person in reference to any item that may assist KENT PEDIATRICS, LLC, in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

CONSENT FOR MAIL
With my consent, KENT PEDIATRICS, LLC, may mail to my home or other designated location any item that may assist KENT PEDIATRICS, LLC, in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked CONFIDENTIAL.

CONSENT FOR E-MAIL
With my consent, KENT PEDIATRICS, LLC, may e-mail to my designated e-mail address any message in reference to any item that may assist in my care.

KENT PEDIATRICS, LLC, may contact me for TPO use, such as appointment reminders, insurance items and any call pertaining to my child's clinical care, including laboratory results, among others.

I have the right to request that KENT PEDIATRICS, LLC, restricts how it uses or discloses my child's PHI to carry out the TPO, However, KENT PEDIATRICS, LLC, is not required to agree to my requested restrictions, but, if it does, it is bound by this agreement.

By signing this form, I am consenting to KENT PEDIATRICS, LLC, use and disclosure of my child's **PHI** to carry out TPO.
I may revoke my consent in writing except to the extent that KENT PEDIATRICS, LLC, has already made disclosure in reliance upon my prior consent. If I do not sign this consent, KENT PEDIATRICS, LLC, may decline to provide services to my child.

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Printed Name of Patient or Legal Guardian — Date

_____
Patient's Name

(UPON REQUEST, PARENT/GUARDIAN WILL BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION)