For Office Use Only: Scanned _____ Entered _____ Verified _____

PATIENT NAME: _____ **BIRTHDATE**_____ **M F** SSN_____
(FIRST, MIDDLE INITIAL, LAST) (SOCIAL SECURITY NUMBER)

Race: White, Black/African Amer., Asian, Native HI/Pacific Is, Amer. Indian/AK Native, prefers not to answer
Ethnicity: Hispanic, Not Hispanic, prefers not to answer
Preferred Language: English, Spanish, Other_____ **Single, Married, Other**_____

BILL PAYER (RESPONSIBLE PARTY): _____ **SSN**_____ MOTHER FATHER GUARDIAN
(FIRST, MIDDLE INITIAL, LAST) (SOCIAL SECURITY NUMBER) [CIRCLE ONE]

MAILING ADDRESS:_____, _____,_____ _____
(CITYOR TOWN) (STATE) (ZIP CODE)

PHYSICAL ADDRESS:_____, _____,_____ _____
(CITYOR TOWN) (STATE) (ZIP CODE)

TELEPHONE: HOME _____ WORK _____ CELL _____

OTHER PARENT: _____ SSN_____ MOTHER FATHER GUARDIAN
(FIRST, MIDDLE INITIAL, LAST) (SOCIAL SECURITY NUMBER) [CIRCLE ONE]

TELEPHONE: HOME _____ WORK _____ CELL _____
LIVES WITH: _____

EMERGENCY CONTACT: _____ TELEPHONE_____
Relationship to patient _____

E-MAIL ADDRESS: _____ **(please print)**
PREFERRED METHOD OF NOTIFICATION (appointment reminders, recall notices): circle one and fill in number legibly
*TELEPHONE (home, work, or cell)*_____, *TEXT* _____, *E-MAIL*

E-mail will be used to send reminders for scheduled appointments and reminders to schedule needed healthcare visits if you do not select a different method.

***Our ability to contact you with important notifications hinges on accurate data. Please call the office or send a message via your child's patient portal whenever your contact information changes (address, e-mail, telephone). Thank you.**

MOTHER'S NAME _____ DOB_____ SSN_____
EMPLOYER_____
FATHER'S NAME _____ DOB_____ SSN_____
EMPLOYER_____

FAMILY MEMBER INFORMATION: Children and others living in child's home.
_____ DOB_____
_____ DOB_____
_____ DOB_____
_____ DOB_____
_____ DOB_____
(Continue on additional paper if needed.)

Referred from: Friend (FR), Relative (FR), Insurance (INS), Midwife (MW), Obstetrician (OB), Physician (MD), Other patients (OP), Office sign(SIGN), Yellow Pages(YP), Siblings are current patients(CP), Self (SE), None
Child's previous physician:_____ or none.

MEDICAL INSURANCE INFORMATION: A copy must be made of your **CHILD'S** insurance card.
Insurance company name: _____
Subscriber's name:_____
SSN_____ DOB_____ GENDER: M F
Group name:_____ Group number:_____
ID Number:_____
Employer name providing insurance:_____
*Does this plan cover all family members? YES NO

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ADDITIONAL MEDICAL INSURANCE COVERAGE:

Insurance company name: _____

SSN_____DOB_____GENDER: M F

Group name:_____Group number:_____

ID Number: _____

Employer name providing insurance:_____

*Does this plan cover all family members? YES NO

RELEASE OF INFORAMTION: I authorize the release of any medical information necessary to process this claim. I authorize you to give the patient listed above reasonable and proper medical care by today's standards. INITIALS_____

ASSIGNMENT OF BENEFITS: I assign to Green Mountain Pediatrics, P.C. all insurance payments for the professional services rendered. I also acknowledge responsibility for payment of all medical fees in the event they are not paid by my insurance plan, any copay due and any services known to be not covered by the health insurance for the above named beneficiary. I understand payment is expected in full if the beneficiary does not have insurance, insurance is not in effect, and/or Green Mountain Pediatrics, P.C. is not a provider for the insurance. I understand any payment plan must be made in advance of services rendered. INITIALS_____

WELL APPOINTMENT CANCELLATION POLICY: There will be a $25.00 per well appointment not cancelled within three (3) business days. INITIALS_____

FORM FEE POLICY: Forms must be mailed with a stamped self-addressed envelope. To ensure privacy and security of health information, we will not FAX any forms as we cannot guarantee confidentiality. For children 2 years and older, there will be a $10.00 charge per physical form for any requests for additional form completion not done during the child's annual checkup. A universal physical form is given at each annual check up. You may make copies of that form to distribute as needed. INITIALS_____

NOTICE OF PRIVACY POLICY: I have received a copy of Green Mountain Pediatrics, P.C. privacy policy (Gold) and office policy brochure. INITIALS_____

CONSENT FOR THE RELEASE OF PHI FOR E-PRESCRIBING: I consent to the disclosure of my prescription medication information by any provider, mental health provider, pharmacy, insurer or prescription benefits manager, specifically including any state or federal health program to Green Mountain Pediatrics and the listed pharmacies for the purpose of my treatment. My consent includes the re-disclosure of protected health information maintained by a drug or alcohol treatment program. I hereby give my consent to Green Mountain Pediatrics, PC including its licensed practitioners and employees, to access, use and disclose my protected health information to

_____

(Pharmacy or Pharmacies)

for the purpose of transmitting prescriptions to them for my treatment. INITIALS_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: With my consent, Green Mountain Pediatrics, PC, (GMP) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to GMP's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. GMP reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to GMP Privacy Office, Mr. Robert Raffone, or inquiring for a personal copy at the receptionist desk.

With my consent, GMP may call my home or other designated location and leave a message on answering machine, voice mail, or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, GMP may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, GMP may mail by postcard a reminder to call the office for an appointment. I have the right to request that GMP restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With my consent, GMP may disclose PHI to the following person(s) who may bring my child to GMP for treatment:

_____Relationship_____

_____Relationship_____

_____Relationship_____

_____Relationship_____

By signing this form, I am consenting to GMP's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, GMP may decline to provide treatment to me.

Signature of Patient or Legal Guardian_____DATE_____