Anne Chen Pediatrics

Patient Registration, Disclosures, and Consent Forms

Patient's Name:____

Date of Birth:__________________ **Male/ Female** **Race:**_____________ **Language:**_______________

Address:____

City/State/Zip Code: ____

Home Phone: ___________________________**Parent's Cell Phone:** ________________________________

Mother/Guardian Name: __________________________**Work Phone Number:** ______________________

Father/Guardian Name: ___________________________**Work Phone Number:** ______________________

Preferred method of contact: (circle only one) **HOME** **MOM CELL** **DAD CELL** **WORK**

Email address we may use for communication regarding your child:_________________________________

FINANCIALLY RESPONSIBLE PARTY (Subscriber on insurance policy)

Responsible Party's Name: ____

Responsible Party's Address: ____

Responsible Party's Home Phone #: __________________________**Cell#**____________________________

PLEASE PRESENT INSURANCE CARD(S) FOR COPYING AND COMPLETE ALL REQUESTED INFORMATION BELOW

Insurance Company #1: ____________________________**Social Security Number:** ____________________

Primary Card Holder Name: ______________________________________**Date of Birth:**_______________

Policy# ___________________________**Group #** _________________**Relationship:** __________________

Insurance Company #2:____________________________**Social Security Number:**_____________________

Primary Card Holder Name: ____________________________________**Date of Birth:**_________________

Policy# _______________________**Group #** ___________________**Relationship:** ____________________

Please share with us how you were referred to our office:

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ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Anne Chen MD and Associates or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Anne Chen MD and Associates is unable to collect from my insurance carrier for whatever reason.

MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of my or my dependent's record that these programs may request, I hereby direct that my payment of my or my dependent's authorized benefits be made directly to Anne Chen MD and Associates or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the Anne Chen MD and Associates Patient Information Privacy Policy. I hereby authorize Anne Chen MD and Associates or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Anne Chen MD and Associates representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Anne Chen MD and Associates to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay, or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my Anne Chen MD and Associates physician or his or her designee.

Patient Signature ____ Date:____________________

Parent/ or Guardian Signature____ Date:____________________

Parent/ or Guardian Printed Name____