Pediatric Associates of Wylie P.A.

Patient Information

Name: _____ Middle: _____ Last: _____ Suffix: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN: ___-___-_____ Sex: M / F DOB: ___/___/___

How did you find out about Pediatric Associates of Wylie, P.A.? _____

Primary Guarantor Information & Insurance

Name: _____ Middle: _____ Last: _____ Suffix: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN: ___-___-_____ Sex: M / F DOB: ___/___/___

Marital Status: _____ Relationship to Patient: _____

Employment Status: _____ Employer: _____

Phone: _____ Work: _____ Mobile: _____

Email: _____

Insurance Company: _____

Insurance Company Address: _____ City: _____ State: _____ Zip: _____

Subscribers I.D. #: _____ Group #: _____

Insurance Company Phone Number: _____

(Please provide your ID card with this information)

Assignment and Release

I hereby authorize payment directly to Dr. Nicole L. Lanman, Pediatric Associates of Wylie, P.A. of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: _____

Pediatric Associates of Wylie P.A.

Consent for Use and Disclosure of Protected Health Information

Our practice reserves the right to modify the privacy practices outlined in the notice:

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices (NPP). I understand and agree to the following:

Pediatric Associates of Wylie, P.A. may use and disclose protected health information (PHI) about me and my child to carry out treatment, payment, and healthcare operations as described in our Notice of Privacy Practices (NPP).

Pediatric Associates of Wylie, P.A. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items, laboratory results and any call pertaining to my child's clinical care.

Pediatric Associates of Wylie, P.A. may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminder cards, and patient statements.

Pediatric Associates of Wylie, P.A. may email any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items, laboratory results and any call pertaining to my child's clinical care.

I have the right to restrict how my child's PHI is used and disclosed and that requests to restrict this information must be submitted in writing. I also understand that Pediatric Associates of Wylie, P.A. reserves the right to refuse requested restrictions.

This agreement will remain in effect without expiration unless I revoke my consent. I may revoke my consent in writing. I understand that if I revoke my consent that it does not apply to PHI that has already been disclosed for normal agreed upon practice operations. I also understand that if I refuse to sign this consent or if I revoke an already signed consent Pediatric Associates of Wylie, P.A. will continue to provide treatment to my child.

Your Name (Last, First)	Your Relationship to the Patient
Patient Name (Last, First)	Patient Date of Birth (MM/DD/YYYY)
Signature of Patient	
Signature of Patient Representative (Required if the patient is a minor or an adult who is unable to sign this form)	
Today's Date (MM/DD/YYYY)	

For Clinic Use Only:	
Date attempt was made to obtain signature (MM/DD/YYYY)	Reason signature was not obtained
Patient Name (Last, First)	Printed name of employee making attempt
Employee signature	Today's Date (MM/DD/YYYY)

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