METROPOLITAN PEDIATRIC SPECIALISTS, P.A. **PATIENT INFORMATION SHEET**

Parent Name _____

Address _____ Apartment _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell # _____

Relationship
Please check appropriate box below.
❑ Father ❑ Step Father
❑ Mother ❑ Step Mother

Employer _____ Position Held _____

Address _____ Work Phone _____

Social Security Number _____ Date of Birth _____

Email address _____

Parent Name _____

Address _____ Apartment _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell # _____

Relationship
Please check appropriate box below.
❑ Father ❑ Step Father
❑ Mother ❑ Step Mother

Employer _____ Position Held _____

Address _____ Work Phone _____

Social Security Number _____ Date of Birth _____

Email address _____

Marital Status: M ___ S ___ D ___ W ___ **In cases of parental separation it is the policy of this office to bill the custodial parent.**

PRIMARY INSURANCE:

Name _____
Group # _____
ID # _____
Policy Holder _____
Effective Date _____

SECONDARY INSURANCE:

Name _____
Group # _____
ID # _____
Policy Holder _____
Effective Date _____

PLEASE LIST ALL CHILDREN THAT ARE PATIENTS AT METROPOLITAN PEDIATRIC SPECIALISTS, PA.:

	Full Name	Date of Birth	Sex
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Name of nearest relative or friend (not at patient's address): _____

Phone: _____ Relationship: _____

AUTHORIZATION AND RELEASE:

I authorize the release of information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Date: ____/____/____ **Signed: X** _____

Over for Consent & Disclosure of Protected Health Information

Metropolitan Pediatric Specialists, P.A.

Pediatric and Adolescent Medicine

STAFF: Thomas R. Stealey, M.D., Diane M. Harrington, M.D., Thomas F. McCarthy, M.D., Randall R. Sercombe, M.D., Kathleen M. Sluhoski, M.D., John W. Baker, M.D., Mary A. Eaton, M.D., David A. Evenson, M.D., Mari B. Daniels, M.D., Judith B. Snook, M.D., Robert W. Snook, M.D., Melissa A. Clark, M.D., Juliana O'Laughlin, M.D., George V. Achett, M. D., Stefan Kramarczuk, M.D., Lisa B. Cronk, M.D., Brandon J. Anderson, M.D., Katharine Tumilty, M.D., Marta Simpson, RN IBCLC, Natalie Rigelman-Hedberg, M.D., Megan Fischer, M.D., Jenna Tate, D.O., Brian D. Hope, M.D.

ADMINISTRATION
Sally Vissers

General Consent

Consent to Treat

I consent to and authorize the physicians, nurses and other healthcare providers at Metropolitan Pediatric Specialists to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

Metropolitan Pediatric Specialists is a teaching clinic. In addition to my clinician and other medical support staff, I may receive care from people who are in training. They are supervised by licensed health care providers. I may decline to have these individuals involved in my care and this will not affect my care or treatment.

Assignment of Benefits/Payment for Services

I authorize payment of any and all benefits to Metropolitan Pediatric Specialists. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with Metropolitan Pediatric Specialists to get payment for my care. If I am eligible for payment from more than one type of coverage, Metropolitan Pediatric Specialists will return any extra payments to the payor. If I have an unpaid bill at Metropolitan Pediatric Specialists, any refunds due to me will be put on my unpaid bill. If there is money left over after my bill is paid, I will get a refund from Metropolitan Pediatric Specialists.

Release of Information

I consent to and authorize Metropolitan Pediatric Specialists to use and disclose my protected health information for:

- Treatment
- Payment
- Healthcare Operation Purposes, including care coordination and quality assessment and improvement activities.

Releases for these purposes may be made to insurance companies, health plans, government programs, e-prescriber databases, payer network organizations, including clinically integrated networks and/or accountable care organizations in which my provider participates, and other healthcare providers involved in my care and treatment. Additionally, I consent to and authorize my insurance company to share my protected health information for the purposes stated above to Metropolitan Pediatric Specialists or a clinically integrated network or accountable care organization in which Metropolitan Pediatric Specialists participates.

Patient Rights and Privacy Practices

You and your family's rights and our privacy practices are posted in main areas within Metropolitan Pediatric Specialists. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider or Metropolitan Pediatric Specialists Privacy Officer.

Other Individuals Authorized to Consent to Treatment

In addition to the legal guardians of the patient, the following persons are authorized to consent to recommended medical care for my child: name and relationship to patient (e.g., grandma, grandpa, daycare provider, etc.):

Name:	Relationship to child:
1. _____	_____
2. _____	_____
3. _____	_____

My signature here means I have read this information and understand it. This consent is valid until revoked in writing.

Patient Name:_____ Date: _____

Signature: _____ Print Name:_____

Relationship to Patient: _____ Name of Interpreter (if used): _____

Telephone consent obtained by (Name/Date/Title):_____