

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

\*\* LIST ALL CHILDREN SEEN BY OUR PRACTICE \*\*

- 1. CHILD'S NAME: \_\_\_\_\_  
LAST FIRST MIDDLE  
NAME CHILD IS CALLED BY: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ SEX: \_\_\_\_\_
- 2. CHILD'S NAME: \_\_\_\_\_  
LAST FIRST MIDDLE  
NAME CHILD IS CALLED BY: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ SEX: \_\_\_\_\_
- 3. CHILD'S NAME: \_\_\_\_\_  
LAST FIRST MIDDLE  
NAME CHILD IS CALLED BY: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ SEX: \_\_\_\_\_

PATIENT'S ADDRESS: _____	PHONE NUMBER: _____
STREET	CELL NUMBER: _____
CITY _____	STATE _____ ZIP _____

POLICY HOLDER: \_\_\_\_\_ SS #: \_\_\_\_\_  
LAST FIRST MIDDLE

FATHER'S NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_  
LAST FIRST MIDDLE

FATHER'S SS #: \_\_\_\_\_

BUSINESS PHONE: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_  
LAST FIRST MIDDLE

MOTHER'S SS #: \_\_\_\_\_

BUSINESS PHONE: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

PERSON RESPONSIBLE FOR BILL (NOT INSURANCE COMPANY) \_\_\_\_\_

BILLING ADDRESS: _____	STREET	CITY	STATE	ZIP CODE
(IF DIFFERENT FROM PATIENT)				

PERSON TO CALL IN EMERGENCY: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

<b>THE INFORMATION ON THIS SHEET IS TRUE AND CORRECT</b>
<p>I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled, including Medicaid, private insurance and other health plans, to this practice. I understand it is my responsibility to pay any deductible or co-insurance amount, and that I am financially responsible for all charges whether or not paid by said insurance.</p> <p>I have received a copy of Children's Medical Group, P.C.'s Notice of Privacy Practices.</p> <p><b>SIGNATURE:</b> _____ <b>DATE:</b> _____</p>

E-Mail address (optional): \_\_\_\_\_