

CHILDREN'S MEDICAL GROUP, P.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGE 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: CITY STATE ZIP

POLICY HOLDER: LAST FIRST MIDDLE SS #:

FATHER'S NAME: LAST FIRST MIDDLE BIRTH DATE:

FATHER'S SS #:

BUSINESS PHONE: OCCUPATION:

MOTHER'S NAME: LAST FIRST MIDDLE BIRTH DATE:

MOTHER'S SS #:

BUSINESS PHONE: OCCUPATION:

PERSON RESPONSIBLE FOR BILL (NOT INSURANCE COMPANY)

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

PERSON TO CALL IN EMERGENCY: PHONE NUMBER:

THE INFORMATION ON THIS SHEET IS TRUE AND CORRECT
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.
I have received a copy of Children's Medical Group, P.C.'s Notice of Privacy Practices.
SIGNATURE: DATE:

E-Mail address (optional):