EVANS PEDIATRIC CLINIC, PC Today's Date: _____________

Patient's Name: ____ **DOB**: _______________ ❑ **Male** ❑ **Female**
Last **First** **Middle**

Please Circle One Choice from <u>Each</u> Line for Race, Language, and Ethnicity:

1. **Race**: White African American Hispanic Asian Native American More than 1 Race
2. **Language**: English Spanish Other_____________________
3. **Ethnicity**: Hispanic Latino Not Hispanic / Latino

Street Address: ____ City: __________________________ State: ________ Zip: ___________

Phone: __________________________________ Email Address: ____

Parent or Legal Guardian Information

Father: ____ DOB: _______________ SSN: ______-____-______
Last First Middle

❑ **Check if address is same patient's** Home phone: ______________________________Cell phone: ____________________________

Address: ____
Street City State Zip

Employer: ____Work phone: ____

Mother: ____ DOB: _______________ SSN: ______-____-______
Last First Middle

❑ **Check if address is same patient's** Home phone: _____________________________ Cell phone: ____________________________

Address: ____
Street City State Zip

Employer: ____Work phone: ____

Insurance Subscriber Name: ____ DOB: ____________ SS#________________________________
(Person who carries insurance) (If not listed above)

PLEASE READ, INITIAL, AND SIGN BACK PAGE

EVANS PEDIATRIC CLINIC, PC

Consent to Treat, Financial Responsibility and Acknowledgement of Receipt of HIPAA

Please initial lines and sign at bottom of page.

______ **I the undersigned legal guardian hereby give consent for examination and / or treatment of the above named patient by staff of Evans Pediatric Clinic, PC. This consent continues until discontinuation by a parent or legal guardian.** I understand and agree with the policy of this office that a parent or legal guardian of my child, who is under 18 years old, must be present while being examined and treated. If I am unable to bring my child to this office I may have another adult bring my child, if I provide Evans Pediatric Clinic, PC with a written authorization form signed by me.

______ **In addition to parent(s)** or legal guardian**, I authorize the following person(s) to bring my child(ren) to Evans Pediatric Clinic, PC** for evaluation and treatment. They have my permission to consent to medical treatment and procedures in my absence. Mark the emergency contact box if you want to designate the person listed as your child's emergency contact.

Name ❑Emergency contact (call if unable to reach parent / guardian)	Relationship to patient	Phone number
Name	Relationship to patient	Phone number
Name	Relationship to patient	Phone number

_______**Financial Responsibility:** I hereby authorize Evans Pediatric Clinic, PC to file claims and assign insurance payments directly to this office for services rendered. **I Understand That I Am Financially Responsible For Charges Not Covered By My Insurance.** I am responsible for providing current and accurate insurance information. I am responsible for co-pays, deductibles, co-insurance, amounts and non-covered items (such as items deemed routine or not medically necessary by my insurance company) as well as outstanding charges my insurance company has not paid in a timely manner. I agree to pay any collection fees, attorney fees, or court costs assessed in the event my account is placed with an outside agency for audit or collection. This authorization is considered valid until revoked by me in writing.

X____ ______________________________

Parent / guardian signature **Date**

HIPAA and PHI (Please initial lines and sign below)

______**I have received a copy of or access to HIPAA policy and procedure for Evans Pediatric Clinic, PC.**

______**Standard Authorization of Use and Disclosure of Protected health Information (PHI):** I hereby authorize the disclosure and re-disclosure of any medical and mental health information acquired in the course of examination and treatment by Evans Pediatric Clinic, PC to my insurance company, any doctor, healthcare facility, legal authority, and any other necessary personnel involved in the care of my child. The privacy of this information may not be protected under the federal privacy regulation. This authorization is considered valid until revoked by me in writing. Additionally, I authorize Evans Pediatric Clinic, PC to contact me using the contact information I have provided.

By signing below, I consent to this authorization, and I acknowledge I have received access to, or a copy of the Privacy Practices of Evans Pediatric, PC., and that I have read and agree to the above statements. .

X____ ______________________________

Parent / guardian signature **Date**