Annual - Family Data & Permissions

PANORAMA PEDIATRIC GROUP

Patient Name:_____ Date of Birth:_____

Patient Phone # (if older than 12 yo and applicable): _____ Email address: _____

Contact Information

Primary Contact Name:_____ Other/Secondary name: _____

Relationship: _____ Relationship: _____

Email:_____ Email:_____

Address:_____ Address:_____

Zip:_____Date of Birth:_____ Zip:_____ Date of Birth:_____

Cell #:_____ Other #:_____ Cell #:_____ Other #: _____

Employer:_____Work #:_____ Employer:_____Work #:_____

☐ **I have provided legal paperwork (divorced, separated, guardianship. If not, method of providing: _____)**

Insurance Information

Primary Insurance Information (if parents are divorced/not married, who has legal responsibility for the health insurance coverage for the child? **Provide appropriate legal paperwork if divorced/separated/alternate custody/guardianship)**

Insurance Co:_____ Subscriber Name: _____ DOB:_____

Subscriber ID: _____ Phone #:_____

☐ **I have supplied my current insurance card to the front desk for scanning**

HIPAA & Privacy Information

Can we contact you at the following? Check box if yes, leave blank if no	Appointment Info	Medical Info
Leave message on home phone?		
Leave message on cell phone?		
Send text message?		
Leave a message on work phone? Extension? _____		
Leave message with another person?		
Send information via regular mail?		
Send information via e-mail/ portal?		

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List anyone else we are allowed to contact and circle yes or no if you authorize the following:					
Name (First & last)	**Relationship**	**Phone # (s)**	**Contact method (circle all that apply)**		
			Schedule & attend appt's?	Yes	No
			Receive and provide disclosure of medical & financial info?	Yes	No
			Make medical decisions?	Yes	No
			Can be used as an emergency contact?	Yes	No
			Schedule & attend appt's?	Yes	No
			Receive and provide disclosure of medical & financial info?	Yes	No
			Make medical decisions?	Yes	No
			Can be used as an emergency contact?	Yes	No

Acknowledgement and Authorization

By signing below, I hereby acknowledge all above information is true and accurate. I also agree to update Panorama Pediatric Group when any information has changed. I acknowledge that Panorama Pediatric Group was provided all financial information, legal documents, and contact information to facilitate care.

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION: I hereby assign all payments for medical services to Panorama Pediatric Group RLLP. I authorize PPG to release my medical records and information to any third-party payers which may need information to process claims for health care benefits, disability, or for performing quality assurance reviews, as required by law. I also give permission to PPG to release information to other health care physicians and health care facilities for the purpose of discussing my conditions, consulting on my case, or for coordinating my medical care. I understand that I am financially responsible for charges not covered by my insurance plan, and I hereby guarantee timely payment in full of any such charges. A photocopy of this assignment and authorization is considered as valid as the original. This authorization will remain in effect until revoked in writing. By signing below, you are acknowledging that you have also been provided, read, and fully understand our policies, including but not limited to, financial, no show & cancellations, divorced/separated.

I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS SET FORTH ABOVE AND AGREE TO THE TERMS AND CONDITIONS THEREIN. I FURTHER UNDERSTAND THAT FAILURE TO COMPLY WITH THIS AND ANY OTHER POLICIES OF PANORAMA PEDIATRIC GROUP MAY RESULT IN TERMINATION OF PROFESSIONAL SERVICES.

Patient (18yo+)/Parent or Legal Guardian Printed Name (if a minor): _____

Patient (18+) / Parent or Legal Guardian Signature (if a minor): _____

Date: _____

Account Number & Team Member's Initials with date (office use only):_____