



PATIENT'S INFORMATION	Name _____ Last First Middle
	Address _____ Number Street Apt#
	City _____ State _____ Zip _____
	Phone _____ Home Work
	Birth Date _____ Month Date Year
	Social Security # _____ - _____ - _____
	Gender _____ Male Female

MOTHER'S (OR GUARDIAN'S) INFORMATION	Name _____ Last First Middle
	Address _____ Number Street Apt#
	City _____ State _____ Zip _____
	Phone _____ Home Work
	Birth Date _____ Month Date Year
	Social Security # _____ - _____ - _____

FATHER'S (OR GUARDIAN'S) INFORMATION	Name _____ Last First Middle
	Address _____ Number Street Apt#
	City _____ State _____ Zip _____
	Phone _____ Home Work
	Birth Date _____ Month Date Year
	Social Security # _____ - _____ - _____

STEP-MOTHER'S INFORMATION	Name _____ Last First Middle
	Address _____ Number Street Apt#
	City _____ State _____ Zip _____
	Phone _____ Home Work
	Birth Date _____ Month Date Year
	Social Security # _____ - _____ - _____

STEP-FATHER'S INFORMATION	Name _____ Last First Middle
	Address _____ Number Street Apt#
	City _____ State _____ Zip _____
	Phone _____ Home Work
	Birth Date _____ Month Date Year
	Social Security # _____ - _____ - _____

FAMILY INFORMATION

Patient lives with (check all that apply):
 Mother
 Father
 Step-mother
 Step-father
 Other (please specify) _____

If you are interested in using your e-mail address, please list here:

Children in household (include patient)	Birth dates
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____

EMERGENCY CONTACT PERSON
(OTHER THAN PARENT OR STEP-PARENT)

Name _____
 Phone _____

PRIMARY INSURANCE INFORMATION

INSURED PARTY'S NAME _____
 INSURED PARTY'S BIRTHDATE ____/____/____
 INSURED PARTY'S SS # _____ - _____ - _____
 INSURED PARTY'S RELATIONSHIP TO PATIENT
 ___Parent ___Step-parent ___Other (_____)
 INSURANCE COMPANY _____
 POLICY NUMBER _____
 GROUP NUMBER _____
 INSURED PARTY'S EMPLOYER _____

SECONDARY INSURANCE INFORMATION

INSURED PARTY'S NAME _____
 INSURED PARTY'S BIRTHDATE ____/____/____
 INSURED PARTY'S SS # _____ - _____ - _____
 INSURED PARTY'S RELATIONSHIP TO PATIENT
 ___Parent ___Step-parent ___Other (_____)
 INSURANCE COMPANY _____
 POLICY NUMBER _____
 GROUP NUMBER _____
 INSURED PARTY'S EMPLOYER _____

PLEASE READ CAREFULLY

CONSENTS AND DISCLOSURES: I voluntarily consent to treatment of myself and/or my dependents by medical healthcare providers of *Peak Pediatrics, LLC*.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: I understand that I am financially responsible and agree to pay all of the charges that are not paid by or billed to insurance or any other third party payer. I also authorize payment directly to *Peak Pediatrics, LLC* for all benefits otherwise payable to me.

RELEASE OF INFORMATION: I authorize *Peak Pediatrics, LLC* to release (verbally or in writing) confidential medical information to any person or entity which may be liable to me or my Practitioner(s) for charges rendered for treatment; and for quality management, utilization review, transfer and follow-up purposes. I also understand that a copy of this agreement may be used with the same effectiveness as the original.

INSUFFICIENT CANCELLATION AND NO-SHOW POLICY: *Peak Pediatrics, LLC* requires **twenty-four hours notice should you need to cancel or reschedule a Well Child visit, and two hours notice for an Acute visit.** You may be charged a mandatory fee for any appointment that is not cancelled as outlined above.

CO-PAY POLICY: It is your responsibility to know how much your co-pay is. If you are unsure please contact your insurance company by dialing the customer service number located on your insurance card. **All co-pays are due at time of service, and a \$10.00 administrative fee will be charged for any co-pay not paid at every visit.**

SIGNING BELOW MEANS YOU HAVE READ AND UNDERSTOOD THE OFFICE POLICIES OF *PEAK PEDIATRICS, LLC*.

**Signature of
Patient/Guardian:** _____

Date: _____