Patient Information

Patient First/Last Name:_____ Preferred Name:_____

Date of Birth:_____ Gender: □ Male □Female

Preferred Language: □ English □Spanish □ Other_____

Race:_____Ethnicity:_____

Patient Address:_____

_____

Patient lives with: **Name**_____**Relationship to child:**_____

Insurance Information

Insurance: _____

Member Name: _____Date of Birth:_____

Member ID: _____ Group ID: _____

***Please present your child's insurance card at the time of visit*.**

Parent/Guardian Information

Parent or Guardian Name:_____ Relationship to patient:_____

Birthdate:_____ SS#:_____ Email: _____

Employer Name: _____Employer phone #:_____

Parent or Guardian Address, if different from patient:_____

Primary phone: _____Secondary phone:_____

Preferred method for contact: □ Phone □ Text □ Email Cellular Provider (required for patient portal):_____

□ I consent to receive text messages from Ascend Pediatrics, LLC regarding my child's care. Message frequency varies. Message and data rates may apply.

Authority/Custody: Joint_____ Exclusive _____

Other Parent or Guardian:_____ Relationship to patient:_____

Birthdate:_____ SS#:_____ Email:_____

Employer Name:_____Employer phone #:_____

Other Parent or Guardian Address, if different from patient:_____

Primary phone: _____ Secondary phone:_____

Patient Name:	**Date of Birth:**

Authorization to seek medical care

I, _____ parent or legal guardian of the above-named child do hereby authorize and consent that the below named person(s) has/have permission to seek medical attention and sign for any medical procedures or treatments deemed necessary for the well-being of my child.

Please list any additional persons who may bring the patient to appointments, or who are authorized to communicate with regarding visits and medical information:

Name:_____ Relationship to patient:_____ Phone #:_____

Name:_____ Relationship to patient:_____ Phone #:_____

Name:_____ Relationship to patient:_____ Phone #:_____

_____

Signature of Parent/Guardian/Patient (over 18y) Date

Authorization and Consent for Treatment, Assigning of Benefits and Financial Responsibility

- I hereby authorize Ascend Pediatrics, LLC to provide medical services to the above names patient and to use and release medical information as required for treatment and healthcare operations.
- I understand that I am financially responsible for all professional charges that I may incur. Payment for these services is due at the time of service. Patients covered under a contracted insurance plan are required to pay any co-payment, deductible, or co-insurance at the time of services or promptly when billed. I understand that insurance cards should be presented at every visit.
- I hereby authorize payment of medical benefits directly to Ascend Pediatrics, LLC. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance will become my responsibility unless otherwise prohibited by state and federal regulations.
- Acknowledgement of receipt of HIPAA NOTICE OF PRIVACY PRACTICES: I have received, or have been given the opportunity to receive, a copy of HIPAA Notice of Privacy Practices for Ascend Pediatrics, LLC.

_____

Printed name of Parent/Guardian/Patient (over 18y) Relationship to patient

_____

Signature of Parent/Guardian/Patient (over 18y) Date