



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. Reply STOP to opt out or HELP for help.

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