



Financial Responsibility Form

Patient's Name: _____ **DOB:** _____

Address: _____
Street City State/Zip

Mother's Information:

Name: _____
Date of Birth: _____
Phone: _____
E-Mail: _____

Previous Patient of Reading Pediatrics: Yes No

Does either parent have other children who are patient's of Reading Pediatrics? Yes No

Father's Information:

Name: _____
Date of Birth: _____
Phone: _____
Email: _____

Previous Patient of Reading Pediatrics: Yes No

Mother's Insurance Name: _____ Adding Baby: YES NO

ID #: _____ Effective Date: _____

Subscriber* Name : _____ Subscriber DOB : _____

Subscriber Relationship to Patient: _____ Copy Card: _____

Father's Insurance Name: _____ Adding Baby: YES NO

ID #: _____ Effective Date: _____

Subscriber* Name : _____ Subscriber DOB : _____

Subscriber Relationship to Patient: _____ Copy Card: _____

** Subscriber is the primary insurance holder – this could be yourself, your spouse/partner, or your parent*

If not adding baby to either insurance above: CHIP Medical Assistance Other: _____

Guarantor (Person Responsible for Payments): Mother Father Other: _____

Address of Guarantor if different from above:

Street City State/Zip

I hereby authorize READING PEDIATRICS, INC to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to READING PEDIATRICS, INC. I understand that I am financially responsible for any balance not paid by my insurance. Balances are to be sent to the guarantor listed above. Payment is expected within 30 days of receipt.

Date: _____ Signature: _____ Print: _____

Date: _____ Received By: _____

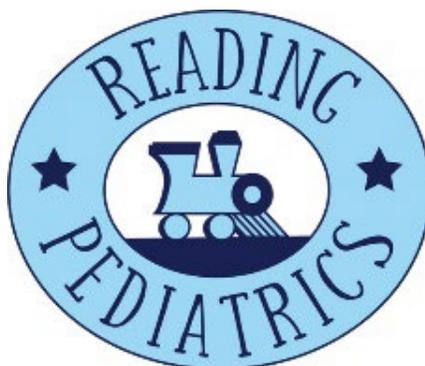
Family History:

(Check all that apply)

Mother**Father****Sibling
(Specify)****Details**

Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy(Seizures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer (Type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Genetic Disorder (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other: Specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Safety:Is there a working smoke alarm on each floor of the child's home/apartment? Yes NoIs your child restrained in a rear-facing car seat when riding in the car? Yes NoAre there any smokers in the household (cigarette, vape, THC)? Yes NoIs your child being placed to sleep on his/her back? Yes NoDoes your child sleep in a separate space (crib or bassinet)? Yes NoAre there any firearms in the home? Yes NoIf yes, are they locked with ammunition stored separately? Yes No**Concerns to address at today's visit:**

Signed: _____**Date:** _____**Print:** _____**Relationship:** _____**Reviewed By:** _____**Date:** _____



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Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____,
 Parent/Guardian Name

have been given access to a copy of Reading Pediatrics Notice of Privacy Practices.

Signature of Parent or Guardian Date

Patient Name Patient DOB Account Number

To read a copy of RPI Notice of Privacy Practices please visit:

<https://www.readingpediatrics.com/policies>