Kids First Pediatrics of Stafford, PC

Patient Information

Last Name | First Name | Middle Name

Date of Birth | Social Security # | M/F

Address | Phone #

City | State | Zip Code

Emergency Contact Other Than Parent | Emergency Contact Phone # | Relationship to child

Parent/Guarantor Information

Parent's Last Name | Parent's First Name | Middle Name

Date of Birth | Social Security # | Marital Status

Address | Phone # | Cell Phone #

City | State | Zip Code

Parent's Employer | Employer's Phone #

Employer's Address

Other Parent's Last Name | Parent's First Name | Middle Name

Date of Birth | Social Security # | Marital Status

Address | Phone # | Cell Phone #

City | State | Zip Code

Parent's Employer | Employer's Phone #

Employer's Address

Insurance Information

Primary Insurance Co. Subscriber's Name

Policy ID # Group # Relationship to Child Subscriber's Date of Birth

Insurance Address Phone # Effective Date

Secondary Insurance Co. Subscriber's Name

Policy ID # Group # Relationship to Child Subscriber's Date of Birth

Insurance Address Phone# Effective Date

I hereby certify that the above information is correct. I authorize my insurance benefits to be paid to the provider and acknowledge that I am financially responsible for any unpaid balances. I also authorize the release of any information required. I further authorize service charges if the bill is not paid after 30 days. I agree to pay collection fees in the amount of 33% of my account balance or a minimum of $50.

Signature Date

HIPAA CONSENT

I understand that Kids First Pediatrics of Stafford, PC may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Practice's Notice of Privacy Practices, which provides information about how the Practice, and individuals involved in my care in the Practice, may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a copy of any current Notice, I understand that I can contact the Privacy Officer at Kids First Pediatrics of Stafford, PC.

I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment, or health care operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the Practice does not agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed protected health information in reliance on my prior consent.

Patient or Legal Surrogate Date Relationship to Patient

Witness Date

EMAIL FOR PATIENT PORTAL NOTIFICATIONS