Blackstone Valley Pediatrics

Name:_____ **DOB:** _____

Address: _____

Cell Phone Number: **Email:**

Protected Health Information (PHI): This will allow your healthcare provider to discuss any of the following issues with your parent or guardian. *Please initial ALL* that you would like your parent or guardian to have permission to access or discuss with your healthcare provider. **Permission for the PHI Initialed below is only valid for 1 year from the signed date below**

- Making Appointments: _____
- Medications: _____
- Lab/Diagnostic Imaging: _____
- STI/HIV Testing: _____
- Discussion of Mental Health Concerns/Status: _____
- Drug/Sexual History: _____

Emergency Contact: _____ Relationship: _____ Phone#: _____

Insurance Company Name: _____

Policy #: _____ Group #: _____

Secondary Insurance (If Any)

Insurance Company Name: _____

Policy #: _____ Group #: _____

Pharmacy Name and City: Phone:

I understand that I am responsible for paying directly any applicable deductible/copayment. This is a mandatory requirement when receiving healthcare services. I understand that if I do not fulfill this requirement, my provider may notify my insurance carrier and seek alternative methods of collection. Failure to meet my financial obligations is a violation of my agreement/contract with my insurance carrier. I also understand that if I have unpaid deductibles or copayments owed to my provider longer than 90 days, my provider may terminate the doctor/patient relationship as a result, subject to the requirements of state and/or federal law.
I understand that my insurance card is required at each visit and if my insurance is not in effect at the time of visit, I understand that I am responsible for payment.

I have read the HIPAA medical information disclosure and understand the above.

Patient Signature: _____ **Date:** _____

Signed off by: _____ **(Office Staff Only)**