

PERSONALIZED PEDIATRICS, LLC
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(860) 495-5232

PATIENT INFORMATION SHEET

PLEASE FILL OUT COMPLETELY

CHILD'S NAME _____ [] M [] F
CHILD'S DATE OF BIRTH _____

PREFERRED PHARMACY:
PHONE: ()

LIVES WITH: [] MOTHER [] FATHER [] BOTH [] OTHER _____
NAMES/AGES OF SIBLINGS: _____

PARENT/GUARDIAN NAME: RELATIONSHIP TO CHILD: ADDRESS: HOME PHONE: () CELL PHONE: () WORK PHONE: () EMPLOYER AND TYPE OF OCCUPATION: DATE OF BIRTH:	PARENT/GUARDIAN NAME: RELATIONSHIP TO CHILD: ADDRESS: HOME PHONE: () CELL PHONE: () WORK PHONE: () EMPLOYER AND TYPE OF OCCUPATION: DATE OF BIRTH:
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OTHER CURRENT RESIDENCE:

WHAT IS THE BEST WAY TO REACH YOU?
IS IT OK TO LEAVE A DETAILED MESSAGE? Y N
IS IT OK TO LEAVE CALL BACK INFORMATION? Y N

HOW DID YOU HEAR ABOUT PERSONALIZED PEDIATRICS?

PRIMARY PEDIATRICIAN: _____
PHONE: ()

MAY WE CONTACT YOUR PRIMARY PEDIATRICIAN TO SHARE (BOTH GIVE AND RECEIVE) INFORMATION REGARDING YOUR MEDICAL CARE AND HISTORY? Y N

PARENT/GUARDIAN

SIGNATURE _____ **DATE** _____

OPTIONAL, BUT VERY HELPFUL:
NAME OF CURRENT INSURANCE COMPANY:

DO YOU PLAN TO SUBMIT FOR REIMBURSEMENT OF TODAY'S VISIT? Y N
MAY WE CONTACT YOU TO LEARN MORE ABOUT YOUR EXPERIENCE? Y N
EMAIL ADDRESS:

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT

I authorize the doctor(s) and staff of Personalized Pediatrics to treat _____.

I agree to pay all fees and charges for such treatment. I agree to pay all charges for services rendered per the terms of this agreement. Charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 14 days of the billing date. In the event legal action should become necessary to collect any unpaid balance due for services rendered to me or my family, I agree that I will pay any reasonable attorney's fees and costs as the Court determines proper. I agree that payments will not be delayed or withheld because of any lawsuits, liens or insurance coverage or the pendency of claims thereon. I understand that not all services and fees are covered by insurance. **I understand that Personalized Pediatrics does not accept any insurance. I understand that I am responsible for paying for all services in full. Such payments are due at the time of service.** I agree that I shall remain financially responsible for the above named patient until I notify you in writing to the contrary. This guarantee is continuing even if the actual patient, if a minor, reaches the age of majority. If the amount due is not paid in full at the time of service, I authorize you or your agent to make credit investigation including employment verification. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. This instrument contains the entire and only agreement between the parties and there are no other promises, representations or warranties, either expressed or implied. The provisions of these agreements shall not be changed or modified except for an instrument, in writing, signed by the parties hereto. You are entitled to a copy of this agreement at the time you sign. Keep it to protect your legal rights.

NOTICE: DO NOT SIGN THIS AGREEMENT BEFORE YOU HAVE READ AND AGREED TO THE CONDITIONS SET FORTH ON THIS FORM. I hereby acknowledge the receipt of a copy of these terms and charges and agree to them as stated and referred to herein.

Parent/Guardian

Signature: _____ **Date:** _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES FOR PERSONALIZED PEDIATRICS, LLC

By law, we are required to provide you with our Notice of Privacy Practices. This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice discusses the circumstances under which we may use or disclose your information.

If you have any questions about this Notice, the name and phone number of our contact person is listed on page three.

I hereby acknowledge that I reviewed a copy of Personalized Pediatrics, LLC Notice of Privacy Practices. I further acknowledge that I have been offered a paper copy of the current Notice which is posted and available on the practice website at www.personalizedpediatrics.com.

Parent/Guardian

Signature: _____ **Date:** _____