THH PEDIATRICS
TENDER HEARTS & HANDS

Welcome to our Practice

PLEASE COMPLETE ALL SECTIONS OF THIS FORM IF YOU ARE 18 YEARS OF AGE OR OLDER.

Patient's First and Last Name

Name: _____ DOB: ___/___/_____ Sex: _____

Home Address: _____

City / State / Zip Code: _____

Primary phone: _____ **H C W** (Circle one) Soc. Sec. #: _____

Secondary phone: _____ **H C W** (Circle one) Driver's Lic. #: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

You may elect to provide THH Pediatrics written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you choose to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, x-ray, prescription refills, appointment information, etc.) on your home voice mail, voice mail at work, and cell phone.

I request and authorize THH Pediatrics to disclose my protected health information as follows:

____ Leave detailed message on my home voice mail (phone # _____)

____ Leave detailed message on my voice mail at work (phone # _____)

____ Leave detailed message on my cell phone voice mail (phone # _____)

____ Leave detailed message with:

1. _____
   Please give full name and relationship to patient **phone number**
2. _____
   Please give full name and relationship to patient **phone number**

PRIMARY INSURANCE INFORMATION

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's DOB: ___/___/_____ Soc. Sec. #: _____

Name of Insurance Co.: _____ Name of Employer: _____

Insurance I.D. #: _____ Group #: _____

Ins. Claims Address: _____

City / State / Zip Code: _____

Copay $: _____ Effective Date: ___/___/_____

SECONDARY INSURANCE INFORMATION

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's DOB: ___/___/_____ Soc. Sec. #: _____

Name of Insurance Co.: _____ Name of Employer: _____

Insurance I.D. #: _____ Group #: _____

Ins. Claims Address: _____

City / State / Zip Code: _____

Copay $: _____ Effective Date: ___/___/_____

AUTHORIZATION & RELEASE

We require a full 24-hour notice prior to your appointment time should you need to cancel. There will be a $50 charge for a cancellation without prior notice, or if a scheduled appointment is missed. This charge will not be covered by your insurance and will be your responsibility.

I authorize this doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to their party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants. **I understand that if this form is not completed in full, I will be responsible for the entire balance due for services as insurance can not be billed without this information.**

_____ _____

Signature of patient Date