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

PATIENT INFORMATION

First & Last Name: ______________________ DOB: ____/____/______ Sex: ________

Patient Email Address: ______________________

Home Address: ______________________

City/State/ZIP Code: ______________________

Primary Phone: ______________________ Secondary Phone: ______________________

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 work voice mail (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: ____/____/______ Name of Employer: ______________________

Name of Insurance Company: ______________________

ID #: ______________________ Group #: ______________________

Insurance Claims Address: ______________________

City/State/ZIP Code: ______________________

Copay $: ______________________ Effective Date: ______________________

AUTHORIZATION & RELEASE

We require a full 24-hour notice prior to your appointment 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 dependents. **I understand that if this form is not completed in full, I will be responsible for the entire balance due for services as insurance cannot be billed without this information.**

Signature of Patient: ______________________ **Date:** ______________________