PLEASE FILL OUT COMPLETELY

PATIENT DEMOGRAPHICS

Child(ren)s Name First ________________Middle Initial ______Last______________ DOB ______ Sex ____

First ________________Middle Initial ______Last______________ DOB ______ Sex ____

First ________________Middle Initial ______Last______________ DOB ______ Sex ____

First ________________Middle Initial ______Last______________ DOB ______ Sex ____

Mailing Address: ____________________________________ Race: White/ Black/ Hisp/ Asian/ Other
PLEASE CIRCLE

____

Primary Phone: (_____) _____-__________ Secondary Phone: (_____) _____-__________

Mother's Name ___________________________ Work Number: (_____) _____-__________

Father's Name ___________________________ Work Number: (_____) _____-__________

Legal Custody: Married___ *Mother ___ *Father___ *Other ______________
(*Please provide court orders to document custody.)

INSURANCE INFORMATION

Patient's Insurance Company: ________________ Policy Holder: ______________

Responsible Party/Policy Holder SSN: ______________ Relationship to patient: ________________
PLEASE SHOW INSURANCE CARD

Primary Pharmacy: ________________________ City: ________________

Emergency Contact Name: ________________ Phone Number: ________________
(Not Living With You)

****Email to access Patient Portal:** ______________________________

Authorization to Treat
I hereby give permission to the Bay Pediatric Center to examine and render treatment to patient listed above.

Financial Patient Agreement
I, the undersigned, am aware that I am financially responsible for all services rendered to me by Bay Pediatric Center which includes co-pays, deductibles and non-covered services, as dictated by my insurance coverage.

I also authorize Bay Pediatric Center to apply for benefits for covered services rendered by the Practice, and request that the payments from my insurance carrier are paid directly to the Practice.

I am aware that if at any time my account is sent to an outside collection agency I will be responsible for payment of an additional 30% of the amount sent.

I am aware that I could be discharged from the practice for multiple no show appointments, for which I do not give 24 hours notice.

I certify that the information I have provided with regard to my identity and insurance coverage is correct, and further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier. I permit a copy of this authorization to be used in place of the original.

Signature______________________________ Date____________________
(Parent/guardian)

The Bay Pediatric Center, LLC
606 Dutchman's Lane
Easton, MD 21601
410-763-8272

PATIENT CONSENT FOR USE AND DICLOSURE
OF PROTECTED HEALTH INFORMATION

With the consent, The Bay Pediatric Center, LLC, may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to The Bay Pediatric Center's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

The Bay Pediatric Center, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Suzanne Brittingham, Privacy Officer at 606 Dutchman's Lane, Easton, MD 21601.

With the consent, The Bay Pediatric Center, LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, The Bay Pediatric Center, LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, The Bay'Pediatric Center, LLC may e-mail my appointment reminder cards and patient statements. I have the right to request that the The Bay Pediatric Center, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to The Bay Pediatric Center, LLC use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, The Bay Pediatric Center may decline to provide treatment to me.

____
Signature of Parent/Guardian or Patient

____________________________________ ____________________
Print Name of Parent/Guardian or Patient Date

____
Child(ren)s Name(s)