NEW PATIENT INFORMATION SHEET

PATIENT INFORMATION

Name: (Last) ________________________________ (First) __________________________ (MI) ____

Address: (No., Street) ____

(City) ___________________________ (State) ______________ (ZIP) _________________

Social Security #: ____________________

Date of Birth: _____________ **Age:** _____ **Sex:** □ M □ F

Diagnosis: _____________________________________

Referring Physician: _____________________________________

RESPONSIBLE PARTY / INSURED INFORMATION

Relationship to Patient: □ Parent □ Other ____________________________

Name: (Last) ________________________________ (First) __________________________ (MI) ____

Address: (No., Street) ____

(City) ___________________________ (State) ______________ (ZIP) _________________

Phone #: ___________________________ **Cell Phone #:** ________________________________

Email: _____________________________________

INSURANCE INFORMATION

☐ **Cash**

☐ **Private Insurance** (Company) ___________________

☐ **Private Insurance** (Company) ___________________ **Medicaid 2d** (Policy #) ________________

☐ **Medicaid Primary** (Policy #) _________________

AUTHORIZATION

I authorize the release of any medical information to Pediatric Potentials, LLC needed to process an insurance claim for services rendered. This authorization shall remain valid until written notice is given by me revoking said authorization.

Patient's or Responsible Party's Signature

____ Date: ___________________

I hereby assign, transfer, and set over to Pediatric Potentials, LLC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. This authorization shall remain valid until written notice is given by me revoking said authorization.

Patient's or Responsible Party's Signature

____ Date: ___________________

PAYMENT

I understand that I am financially responsible for all charges due upon completion of service; and that there is a $25 fee for cancelling without notice. Should my account be referred to an outside collections agency, I agree to pay all collection costs, attorney fees and court costs.

Patient's or Responsible Party's Signature

____ Date: ___________________