

Acct# _____

Please Note: Read and complete the following form in its entirety. Form must be completed and signed in order to render medical care. Form must be signed by parent/legal guardian.

If you have: child/children with different information, a form must be completed for each child.

A. Patient Information

<u>First Name</u>	<u>M.I.</u>	<u>Last Name</u>	<u>D.O.B</u>	<u>Insurance Provider</u>
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____

B. Parent Information

Father Name: _____ **SSN:** _____
Address: _____ **City** _____ **ST** _____ **ZIP** _____
Phone # Home _____ **Work** _____ **Cell** _____
Employer: _____ **DOB:** _____

Mother Name: _____ **SSN:** _____
Address: _____ **City** _____ **ST** _____ **ZIP** _____
Phone # Home _____ **Work** _____ **Cell** _____
Employer: _____ **DOB:** _____

Name of Relative in the area: _____ **Phone:** _____

Relation to child: _____

Authorization:

- a. I authorize Louisville Pediatric Specialists, PSC to render medical care to my child/children.
- b. I authorize care for my children when accompanied by the following individuals should I not be able to accompany them to the office for medical care. _____

- c. I authorize Louisville Pediatric Specialists, PSC to release medical records on behalf of my child/children to any specialists to whom he/she has been referred to for care.
- d. I authorize Louisville Pediatric Specialists, PSC to release to my insurance companies any information needed to file claims for fees or services rendered and to provide the companies with any information they may need to adjudicate my claim.
- e. I authorize direct payment by my insurance companies to Louisville Pediatric Specialists, PSC.

Agreement:

- a. I agree to be financially responsible for any and all fees that are not covered by my insurance companies. I understand that interest or other charges may be added to my financial account should that account become delinquent or be placed with a collection agency.
- b. I will assume financial responsibility for any such charges. This office is not responsible for any dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurer or employer.

Print Name: _____ Date: _____

Signature: _____