PATIENT INFORMATION

Patient Name:____ DOB:___________________________

Parent/Legal Guardian: __________________________________ Relationship to Patient:____________________
Social Security #:____________________________ Male/Female single/married/divorced/widow
Language Preference : ______________________ Pharmacy Preference:___________________________
Race: Caucasian / African American / Refuse / Other _____________ Ethnicity: Hispanic: Yes / No / Refuse

Home / Cell Phone (If parent who): ____

Email Address:____

Emergency Contact: __________________________________ Phone Number:_________________________
Relationship to Patient:____

Physical Address:____

Mailing Address (if different):____
Primary Care Provider: ______________________________________Number:_____________________________

Authorization for Treatment

I hereby request and authorize Surf Pediatrics and Medicine, PC clinicians and his/her staff to perform routine medical, diagnostic, therapeutic and/or surgical services which are deemed advisable by the clinician. Please note any lab work drawn in our office is sent to Lab Corp who will bill your insurance company and you separately.

Consent to the Use and Disclosure of Protected Health Information, Receipt of Notice of Patients' Rights and Responsibilities and Notice of Privacy Practices, and Online Interaction/Communication Policy

I understand that Surf Pediatrics and Medicine, PC originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I consent to the information outlined in *Surf Pediatrics and Medicine Notice of Patients' Rights and Responsibilities and Notice of Privacy Practices* that provides a more complete description of medical information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed, and that the organization is not required to agree to the restrictions requested. I request the following restrictions to the use or disclosure of my health information (blank, if none requested): ____

I consent to the information outlined in *Surf Pediatrics and Medicine Online Interaction/Communication Policy* that uses internet-based communications, registration, and other modes of interaction to facilitate my receipt of health care, as the practice deems necessary.

Assignment of Benefit Agreement for Insurance Companies Payments

I hereby authorize and direct my insurance carrier(s), including Medicaid, Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Surf Pediatrics and Medicine, PC for medical or surgical services or items rendered to myself and/or my dependents regardless of my insurance benefits, if any. We bill insurance as a primary care, we **DO NOT** bill as an urgent care. I understand that I am responsible for any amount not covered by insurance and agree to our financial policy.

Authorization to Release Information and Financial Responsibility Guidelines

I hereby authorize Surf Pediatrics and Medicine, PC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Signature:____ Date:___________________________