

# Darien Pediatric Associates, LLC

106 Noroton Ave, Darien, CT, 06820

Phone: (203) 655-9741 – Fax: (203) 655-9249

**\*\*\* CURRENT INFORMATION SHEETS ARE REQUIRED YEARLY BY YOUR INSURANCE COMPANY \*\*\***

## CHILD(REN)'S INFORMATION

NAMES SHOULD BE EXACTLY AS PRINTED ON INSURANCE CARD

Name: (First) (MI) (Last)	Cell Phone:	Date of Birth:	Gender:	Insurance ID #:
Name: (First) (MI) (Last)	Cell Phone:	Date of Birth:	Gender:	Insurance ID #:
Name: (First) (MI) (Last)	Cell Phone:	Date of Birth:	Gender:	Insurance ID #:
Name: (First) (MI) (Last)	Cell Phone:	Date of Birth:	Gender:	Insurance ID #:
Name: (First) (MI) (Last)	Cell Phone:	Date of Birth:	Gender:	Insurance ID #:

## MOTHER'S INFORMATION

Name: (First) (MI) (Last)	Date of Birth:	Marital Status:	Social Security #:
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	E-mail:
			Employer/Occupation:

## FATHER'S INFORMATION

Name: (First) (MI) (Last)	Date of Birth:	Marital Status:	Social Security #:
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	E-mail:
			Employer/Occupation:

## EMERGENCY CONTACT INFORMATION – (SOMEONE OTHER THAN PARENTS)

Name: (First) (MI) (Last)	Relationship To Child:
Home Phone:	Cell Phone:
Work Phone:	

## INSURANCE INFORMATION

CARRIER OF INSURANCE:  MOTHER  FATHER  OTHER (IF OTHER, PLEASE FILL IN BELOW)

Insurance Company Name:	Identification # / Group #:	Effective Start Date:
Subscriber Name:	Subscriber SS#:	Subscriber Date of Birth:
		Relationship To Child:

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of Darien Pediatrics Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and I may request a copy of any amended notices at each appointment.

## I AGREE TO THE ASSIGNMENT OR FINANCIAL RESPONSIBILITIES SHOWN BELOW AND HIPAA PRIVACY PRACTICES ABOVE

I authorize Darien Pediatric Associates, LLC, to treat my child/children and the release of medical information as necessary for the completion of insurance, school and camp forms. I authorize payment directly to Darien Pediatric Associates, LLC, for any and all medical benefits payable to me under the terms of my insurance. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that I am financially responsible for all co-payments, deductibles and any charges not covered under my insurance benefits. I also understand I am responsible for advising Darien Pediatric Associates, LLC, of any changes to my insurance. If I do not have insurance coverage, I understand I am responsible for payment in full. Payments of co-pays are due on the date of service. Failure to pay the co-payment at that time will result in an additional billing charge of \$5.00. I understand that 24 hours notification is required for cancelling any physical appointment; failure to do so will result in a \$50 cancellation fee. A \$20 fee will be charged for any other missed appointment. This assignment will remain in effect until revoked in writing.

Signed (Adult Responsible for Payment):	Print Name:	Date:
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