

Vernon Hills Pediatric Associates, Ltd.

Primary Insurance Information:

Insurance Co: _____ Effective Date _____
Policy Holder: _____ Policy Holder DOB: _____

LIST ALL CHILDREN (receiving treatment at this office)

(for office use only)

VHP# _____ Name _____ M/F _____ DOB _____
VHP# _____ Name _____ M/F _____ DOB _____
VHP# _____ Name _____ M/F _____ DOB _____
VHP# _____ Name _____ M/F _____ DOB _____
VHP# _____ Name _____ M/F _____ DOB _____

Child(ren) Reside with (provide name): _____

Child(ren's) Home Address: _____
Street City ST ZIP

Phone: _____
Home Cell

Parent/Legal Guardian Information:

Name: _____ Relationship: Married [] Divorced [] Single [] Other []
Mother [] Father [] Guardian []
Address: _____ Same as Child(ren) []
Social Security Number _____
Phone: _____ Date of Birth _____
Employer Name and Address: _____
Work Phone: _____ May we contact you? Yes [] No []

Name: _____ Relationship: Mother [] Father [] Guardian []
Address: _____ Same as Child(ren) []
Social Security Number _____
Phone: _____ Date of Birth _____
Employer Name and Address: _____
Work Phone: _____ May we contact you? Yes [] No []

In the event the bill is not paid and is turned over to our collection agency, information will be provided and may include but not limited to: name, address, phone, social security number, and employer information.

I hereby authorize Vernon Hills Pediatric Associates, Ltd., to release to my child(ren's) insurance company or its representative any information including the diagnosis and records of any treatment or examination. I authorize and request my insurance company to pay directly to Vernon Hills Pediatric Associates, Ltd. the amount due on any pending claim for services rendered to my child(ren).

Signature of Parent/Guardian

Date

Turn Page Over

Release/Use of Confidential Information Receipt of Notice of Privacy Practice Form and Protected Health Information Disclosure Authorization Procedure

I, _____, hereby acknowledge receipt and understand the Notice of Privacy Practices of Vernon Hills Pediatric Associates, Ltd. I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available for my review.

I give my consent to Vernon Hills Pediatric Associates, Ltd. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information for my child(ren) that are listed on the reverse side of this form.

In order to communicate your Protected Health Information (lab tests, diagnostic procedure, etc.) in a timely manner in compliance with the Health Insurance Portability and Accountability Act, we request that you complete and sign this form. This form confirms your authorization on what manner you prefer Vernon Hills Pediatric Associates, Ltd. to use and disclose your Protected Health Information and what information can be disclosed.

The type of Protected Health Information authorized to be used and/or disclosed are (please check appropriate boxes):

- Any diagnostic test result Diagnosis Other: _____

Please include a phone number where you can be reached. **Please note that if you are unavailable, we will leave the information on voicemail and/or answering machine.**

- Home _____ Work _____ Cell _____

This authorization will be in effect for one year from the date of signature. I may revoke this at any time by giving written notice to Vernon Hills Pediatric Associates, Ltd. I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.

I have read and understand the content of this authorization form and I agree with all statements made in this authorization. I further understand that by signing this form, I am confirming my authorization for use and/or disclosure of the Protected Health Information described in this form with the people and/or organizations named in this form.

Signature _____
Patient, Parent or Legal Guardian

Date _____

Relationship to Patient _____