BIG APPLE Pediatrics

Cathy Ward, MD
315 West 70th St, Suite 1K
New York, NY 10023

Welcome to Big Apple Pediatrics! We strive to give you competent and compassionate pediatric medical care at each visit. Please complete the following information.

Today's Date: _____

PATIENT & PARENT/GUARDIAN INFORMATION

☐ Mother ☐ Guardian

Name: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____

☐ Father ☐ Guardian

Name: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____

Child

Name: _____
Gender: _____
Age: _____
Birth Date: _____
Child's Home Address: _____
Insured Under Whom? _____

Emergency Contact

Name: _____
Relationship to Patient: _____
Phone: _____

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Primary Insurance

Insured's Name: _____

Relationship: _____

Birth Date: _____

Employer: _____

Occupation: _____

Ins. Co. Address: _____

City, State, Zip: _____

Group #: _____

Policy #: _____

Co-pay: _____

Secondary Insurance

Insured's Name: _____

Relationship: _____

Birth Date: _____

SSN: _____

Insurance Company: _____

Group #: _____

Policy #: _____

Co-pay: _____

AUTHORIZATION AND RELEASE

I authorize the doctor to release my information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Parent or Guardian Signature Date

LATE CHARGES

If I do not pay the entire new balance within 25 days of the monthly billing cycle a late charge 1.5% on the balance that's unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in Dr. Ward being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of defer on payment of the account, I agree to collection costs and reasonable attorney fees incurred in attempting to collect past due payments.

_____ _____

Parent or Guardian Signature Date

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RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Today's Date: _____

The Notice of Privacy Practices describes how "Protected Health Information" about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Big Apple Pediatrics is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our pediatric office, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our office. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

_____

Signature of Patient/Healthcare Agent/Guardian/Relative
(This signature indicates having received a copy of the Notice of Privacy Practices)

- ☐ Patient is unable to sign due to medical reasons
- ☐ Patient refuses to sign.
- ☐ Other (please explain):

This acknowledgment form will become part of your permanent medical record.