

Welcome To Our Office!

Name: _____ Today's Date: _____
 First Middle Last

Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: () _____ Birthdate: _____
Email Address: _____ May send information here? _____
Mother's name : _____
Cell number: _____ Work number: _____
Father's name : _____
Cell number: _____ Work number: _____

Responsible party is whom ever carriers the Insurance plan,

Responsible Party: _____ Relationship to Patient: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: () _____ Birthdate: _____
Occupation: _____ SSN: _____
Employer: _____
Work Phone: () _____

In case of emergency, contact: _____ Relationship: _____
Home Phone: () _____ Work Phone: () _____

Who may we thank for this referral? _____

Primary Insurance

Name of Insurance Company:

Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____ Insured's
DOB _____
Group Number: _____ Policy ID Number: _____

Secondary Insurance

Name of Insurance Company:

Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____
Group Number: _____ Policy ID Number: _____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

Our practice charges for missed appointments, if you can not keep your scheduled appointment please call us with in 24 hours. **Our No Show fee is \$25.00 for sick visits and \$50.00 for well visits and After-hours Nurse Triage is \$22.50. If your chart is being transferred out to another provider (excluding specialists) there is a \$25.00 charge. Please Note: all accounts must be in good standing for any charts to be released.**

Initial: _____

Consent to Treat

I hereby give my consent to Dr. Cohen and authorize him to provide medical treatment to my child _____. I understand that Dr. Cohen will explain my child's condition (s), foreseeable risks, and methods of treatment for my child's condition before treatment is provided. I authorize Dr. Cohen to perform any additional or different treatment, which is thought necessary should, in an emergency situation, a condition be discovered which was not known previously.

I have reviewed this office's Notice of Privacy Practices, which explains how medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Responsible Party: _____

Date: _____

I authorize the release of any medical information necessary to process my claim. Signed: _____ (Patient or responsible party) Date: _____

I authorize payment of medical and surgical benefits to Cedar Park Pediatrics. Signed: _____ (Patient or responsible Party) Date: _____
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