Aventura Pediatrics, LLC

Leah Glaser, M.D. Priscila Vidal, A.P.R.N. Karina Bernetti, M.D.

Patient name: ______________________________ Sex: M/F DOB: ______________________

Race/Ethnicity: __________ Primary language: ______________ email: ____________________

Local Address: ______________________________ apt#: _____ St: _______ zip: __________

Permanent Address: ___________________________ apt# ______ St: _______ zip: __________

Sibling's Name: ____________________ DOB: ______________

Sibling's Name: ____________________ DOB: ______________

Sibling's Name: ____________________ DOB: ______________

Mother's Name: _________________________ SSN# _______________ DOB: _____________

Father Name: ___________________________ SSN# _______________ DOB: _____________

Legal Guardian Name: ____________________ SSN# _______________ DOB: _____________

Legal Custody: Mother/ Father/Legal guardian name: ______________________________

Mom cell: _________________ Dad cell: ________________ Guardian cell: ________________

Names of persons authorized to bring child/children to doctor's visits:

1. ______________________________ Relationship to child: ___________________________

2. ______________________________ Relationship to child: ___________________________

3. ______________________________ Relationship to child: ___________________________

Who referred you to our office? ____

*Pharmacy Name: _______________________ Phone Number: _________________________

Primary Insured's name: ___________________________ DOB: _________________________

Insurance Company name: __________________________ ID# _________________________

Group# ______________________________ Phone#: _________________________________

****PLEASE PRESENT YOUR PHOTO I.D. AND INSURANCE CARD WITH THIS PACKET*****

Responsible Party Information:

Name: ______________________________ Relationship to Patient: ______________

SS# ______________________________ DOB: ______________

Address: ____
Street City State Zip

Employer: ______________________________

Business Phone # ______________________________

Emergency Contact: ______________________________ Phone ______________

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize any insurance benefits to be paid directly to the physician, Dr. Leah Glaser or Aventura Pediatrics LLC. I understand that if insurance payment is made directly to me by the insurance company, that the amount received is the property of Aventura Pediatrics LLC and will be forwarded appropriately. ____________ (Initial)

AUTHORIZATION TO RELEASE INFORMATION: I authorize Aventura Pediatrics LLC under HIPAA regulations to release my information including information regarding diagnosis and treatment to the insurance company necessary to collect benefits for the services provided. ____________(Initial)

STATEMENT OF FINANCIAL RESPONSIBILITY: We cannot accept divorce decrees as assignment of responsibility for your child's medical bills. The parent accompanying the child is responsible for payment, unless prepaid via credit card prior to visit. Copays and deductible payments are due at time of service. I understand that it is my responsibility to know my personal insurance policy. I understand that I am financially responsible for any non-covered services that are provided. Aventura Pediatrics LLC will perform all necessary procedures to collect from your insurance; however, if unable to collect, I understand that the balance is my responsibility. I, the undersigned, agree to pay for any attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account. ____________(Initial)

APPOINTMENT NO-SHOW POLICY: Any appointment that is not cancelled prior to appointment time is subject to a $25.00 no-show fee. ____________(Initial)

Signature of Responsible Party: ______________________________ Date: ______________

Acknowledgement of Receipt of Notice of Privacy Practices:

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed: ______________________________________ Date: ______________________

Print Name: ___________________________________ Date: ______________________

If not signed by the patient, please indicate relationship:

_____ parent or guardian of minor patient

_____ guardian or conservator of an incompetent patient

Name of Patient: ______________________________________

For office use only:

_____ Signed form received by ____________________________

_____ Acknowledgement refused:

Efforts to obtain:

____

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Reason for refusal:

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