Great Destinations Pediatrics P.C.

PATIENT'S INFORMATION

Patient's Legal Name_____ **DOB**:_____

Sex: M/F/T/Non-Binary **Nickname** (*if any*) _____

Address_____
Street City St Zip

Phone (_____) _____-_____ **Email** : _____

INSURANCE INFORMATION

Primary insurance company name	Name of Policy Holder	Policy/ID Number	Group Number
Primary insurance company name	Name of Policy Holder	Policy/ID Number	Group Number

Emergency Contact:

Name: _____ Phone Number: (_____)_____-_____

Relationship: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize payment directly from my insurance company to the physician's of Great Destinations Pediatrics for Medical treatment(s) provided.
I understand that payment in full of my responsible portion is required at the time of visit. If Great Destinations Pediatrics (GDP) is not a provider on my insurance, full payment is due on the date of service. If GDP is a provider on my insurance, then any deductibles, co-pays, or percentages are due at the time of service. Additionally, should it be necessary to assign my account for collections, it is hereby agreed that I shall pay reasonable charges, attorney's fees, and all other costs.
I hereby authorize GDP to examine and treat me when necessary. I also authorize the release of my protected health information, acquired in the course of examination to carry out treatment, payment and heath care operations of myself.
FINANCIAL/OFFICE POLICY & HIPAA:
I have read and understand the foregoing financial and office policy and agree to abide by the terms of this policy. I also acknowledge that I have received a copy of the Notice of Privacy Practices, including Omnibus Rule.

Responsible Party Signature Date