CORBIN PEDIATRIC ASSOCIATES, PSC

DATE: _______________

Patient Name: ____ Date of Birth: ______________
Last First MI Maiden

Social Security Number: ______________________ Gender: _____ Female _____ Male

Permanent Address: ____
Street Apt. # City State Zip Code

Phone Number: (____) __________________ (____) __________________ (____) __________________
Home Work Cell Phone/Pager

Siblings Who Are Patients In The Practice: ____________________________________

Mother's Name: ______________________________ Father's Name: ______________________________
Last First MI/Maiden Last First

Mother's Employer: ______________________________ Father's Employer: ______________________________
Name Phone Name Phone

Responsible Party: ______________________________ Social Security Number: ______________________
(Last, First, MI)

Date of Birth: ______________________ Relationship to Patient: ______________________

Address: ____
Street City State Zip Code

Phone Number: (______) __________________ (______) __________________ (______) __________________
Home Work Cell Phone/Pager

Emergency Contact: ____
(Not in Home) Name Phone Relationship

PRIMARY INSURANCE DATA/VERIFICATION

Insurance: ____
Name Phone # Effective Date

Address: ____
Street City State Zip Code

Subscriber: ____
Name "As is on Card" ID/Cert/Policy # Group #

Date of Birth: ____________ Social Security Number: ________________ Relationship to Patient: __________

SECONDARY INSURANCE DATA/VERIFICATION

Insurance: ____
Name Phone # Effective Date

Address: ____
Street City State Zip Code

Subscriber: ____
Name "As is on Card" ID/Cert Policy # Group #

Date of Birth: ____________ Social Security Number: ________________ Relationship to Patient: __________

Release of Information: I authorize the release from my medical records or the records of the person for whom I am duly authorized to do so, of such medical and/or psychiatric information as may be required by:

1. Any health, sickness, accident insurance carrier, workman's compensation, or agency (social welfare, governmental) which is legally responsible, or which Corbin Pediatric Associates, PSC (CPA), has good cause to believe is legally responsible for all or any part of the charges and/or professional fees.
2. Physicians, laboratory or health care facilities rendering professional care to the patient.
3. The Peer Review Organization responsible for reviewing medical care under Public Law 92-603.

The signed authorization complies with KRS 412.215 rules governing the release of PRIVILEGED information. It assures confidentiality of information and permits CPA to correspond with those agencies/persons having legitimate interest in the course of care rendered.

Procurement of Information: I/We authorize the release of any medical records from other physicians, hospitals or health care facilities that CPA needs for my present medical care of the present medical care of the person for whom I am duly authorized to sign.

Guarantee of Payment: I/We agree to be responsible to CPA for charges resulting from services rendered at their prevailing rates. I/We agree all bills are due in full upon demand. Should I/we fail to honor this agreement, I/we agree to pay any collection cost or attorney fees resulting from the collection of my accounts.
No granting of extensions, indulgences or forbearances to the patient or any responsible party and no delays or lack of diligence on the part of CPA in enforcing any rights shall in any manner release the undersigned liability. If the undersigned is more than one person this obligation shall be joint and several.
I/We agree that CPA is not party to any disputed claim or peer review decision which affects payment of any claim filed on my behalf and that upon request for payment from CPA I/we agree to pay any outstanding balance.

Assignment of Benefits: I/We hereby assign all rights and privileges and authorize payment directly to CPA for any claim filed on my behalf or the behalf of the person for whom I am duly authorized to sign for insurance benefits. I/We agree this assignment is primary to any assignment given after this date including any cost relative to attorney fees. I/We also understand that I/we am financially responsible to CPA for charges not covered by this assignment or not paid on a timely basis by the insurance company.

CONSENT TO TREATMENT

I voluntarily authorize the rendering of such care, including diagnostic procedures and medical treatment, by authorized agents and employees of Corbin Pediatric Associates, PSC (CPA) and its medical staff, or their designees, as may in their professional judgment be deemed necessary or beneficial, and may include testing for HIV (the virus that causes AIDS) and other blood borne diseases. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures.

CERTIFICATION: I acknowledge that I have read and understand all the information contained on the front and back of this form. I certify that I am the patient, or I am duly authorized by the patient to execute the above consent and accept its terms. I also understand that this consent may be revoked at any time, except to the extent that action has already been taken, by the patient/duly authorized agent and will expire automatically ONE year from the date below.
I understand that I am responsible for any co-pays, deductibles, non-covered services or I am uninsured and will pay in full.

(Signature of Patient or Representative)	(Relationship to Patient)	(Date)

(Witness)	(Date)	(Witness)	(Date)