WESTSIDE PEDIATRICS

Indicate Primary Care Physician: ☐ Solanki ☐ Felkel ☐ Welch

***THANK YOU* for choosing our office. In order to serve you properly, we will need the following information. (Please print)**

PATIENT'S LAST NAME		PATIENT'S FIRST NAME		PATIENT'S MIDDLE NAME
DATE OF BIRTH	SEX	REFERRED BY	YOUR OTHER FAMILY MEMEBERS SEEN IN THIS OFFICE	
HOME ADDRESS (Street/City/State/Zip)			HOME PHONE	
ETHNICITY ☐ WHITE NOT HISPANIC ☐ HISPANIC OR LATIN		RACE	LANGUAGE	

RESPONSIBLE PARTY (This is who statements will be made out to) (Place their name and info below)

LAST NAME	FIRST NAME	MI	RELATIONSHIP	HOME PHONE
ADDRESS (Street/City/State/Zip)				MOBILE PHONE
EMPLOYER NAME AND ADDRESS (Street/City/State/Zip)				WORK PHONE
SOCIAL SECURITY NUMBER (Needed for insurance processing)		DATE OF BIRTH		EMAIL ADDRESS

SPOUSE OR OTHER PARENT (Place their name and info in the columns below)

LAST NAME	FIRST NAME	MI	RELATIONSHIP	HOME PHONE
ADDRESS (Street/City/Zip)				MOBILE PHONE
EMPLOYER NAME AND ADDRESS (Street/City/State/Zip)				WORK PHONE
SOCIAL SECURITY NUMBER (Needed for insurance processing)		DATE OF BIRTH		EMAIL ADDRESS

INSURANCE INFORMATION (Place the company name and billing info below)

INSURANCE COMPANY	SUSCRIBER NAME (Person policy is written under)	
CLAIMS ADDRESS (On the back of the card)	SUSCRIBER NUMBER	GROUP NUMBER

PREFERRED PHARMACY (Place Name and location below)

EMERGENCY NOTIFICATION(other than parents) (Fill in below)

NAME	RELATIONSHIP	PHONE

OVER PLEASE

WESTSIDE PEDIATRICS

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Westside Pediatrics creates and maintains health records and other information describing among other things, my health history, symptoms, examinations, and test results, diagnoses and other treatment, prescriptions, and any plans for future care or treatment.

I have been provided with a **NOTICE OF PRIVACY PRACTICES** that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their **NOTICE AND PRACTICES** and prior to implementation, will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, ect.) and that the organizations is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, prescribing, payment, and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

*Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment, or health care operations without my prior written authorization, except as otherwise provided by law.

*A photocopy, fax, or scan of this consent is as valid as the original.

*I have the right to request that the use of my **PROTECTED HEALTH INFORMATION**, which is used or disclosed for the purposes of treatment, payment, or health care operations be restricted. I also understand that the practice and I must agree to any restriction in writing that I request on the use and disclosure of my **PROTECTED HEALTH INFORMATION** and agree to terminate any restrictions in writing on the use and disclosure of my **PROTECTED HEALTH INFORMATION** and which have been previously agreed upon.

I grant permission to view online external prescription history from other healthcare providers with whom I have sought care. I authorize **WESTSIDE PEDIATRICS** to contact me via email, which I have provided, regarding health issues and appointment reminders.

EMAIL_____(INITIAL_____)

I authorize Westside Pediatrics to contact me by automated messaging. This may include, but is not limited to appointment reminders, lab results, health maintenance, Rx confirmation, and general notifications.

VOICE MESSAGING at (_____) _____-_____

PREFERRED TIME OF CALL (CIRCLE ONE) MORNING AFTERNOON

(PATIENT'S NAME PRINTED) (PATIENT'S DATE OF BIRTH)

_____ _____

(PATIENT'S SIGNATURE OR GUARDIAN'S IF PATIENT IS A MINOR) (DATE)

_____ _____