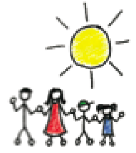
BRIGHT HORIZONS
PEDIATRICS, P. C.



Patient Name	Gender	Date of Birth	Race	Ethnicity
______________________________	_____	__________	__________________	__________________
______________________________	_____	__________	__________________	__________________
______________________________	_____	__________	__________________	__________________
______________________________	_____	__________	__________________	__________________
______________________________	_____	__________	__________________	__________________
______________________________	_____	__________	__________________	__________________

Parent Name ____________________________________

Street ____

City ____________________ State _____ Zip _________

Email ____

Preferred Language ______________________

Phone (please * the preferred number)

Home _________________________

Work __________________________

Cell ___________________________

Others able to make health care decisions for the patient

Name ____ Relationship to Patient __________________

Name ____ Relationship to Patient __________________

Responsible Financial Party Information

Name ____ Relationship to Patient __________________

Address same as above

Married ___ Divorced ___ Single ___

Street ____

City ____________________ State _____ Zip _________

Phone ________________________________

Insurance Information

Primary Insurance __________________________________

Policy Owner Name __________________________________

Policy Owner Address same as above

Street ____

City ____________________ State _____ Zip _________

Phone ________________________________

Policy Owner Relationship to Patient _______________

Policy Owner Date of Birth _______________

Policy Owner SSN _____________________

Member Insurance ID __________________________

Policy Group ID ______________________________

Secondary Insurance (if applicable) ________________________ Policy Owner Relationship to Patient ________________

Policy Owner Name ____________________________________ Policy Owner Date of Birth ________________

Policy Owner Address same as above Policy Owner SSN _______________________

Street ____ Member Insurance ID _____________________________

City ______________________ State _____ Zip _________ Policy Group ID _________________________________

Phone ____________________________________

Release/Use of Confidential Information Receipt of Notice of Privacy Practice Form and Protected Health Information Disclosure Authorization Procedure

I, ___________________________________, hereby acknowledge receipt and understanding of the Notice of Privacy Practices of Bright Horizons Pediatrics, P.C. I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available for my review.

I give my consent to Bright Horizons Pediatrics, P.C. to use or disclose, for the purpose or carrying out treatment, payment, or health care operations, all information for my child(ren) that are listed on the reverse of this form.

In order to communicate your Protected Health Information (lab test, diagnostic procedures, etc.) in a timely manner, in compliance with the Health Insurance Portability and Accountability Act, we request that you complete and sign this form. This form confirms your authorization as to what manner you prefer Bright Horizons Pediatrics, P.C. to use and disclose your Protected Health Information and what information can be disclosed.

The type of Protected Health Information authorized by you to be used and disclosed are diagnosis and any diagnostic test results.

Please include on the reverse a contact number where you prefer to be reached and where, in the event you are unavailable, we are permitted to leave information on voice mail or answering machine.

This authorization will be in effect from the date of signature. I may revoke this at any time by giving written notice to Bright Horizons Pediatrics, P.C. I understand that I may not revoke this authorization for any actions taken before the receipt of my written notice to revoke this authorization.

I have read and understand the content of this authorization form and I agree with all statements made in this authorization. I further understand that by signing this form, I am confirming my authorization for use and/or disclosure of the Protected Health Information described in this form with the people and/or organizations named in this form.

Signature ____ Printed Name ______________________________________

Date ____________________