

Purohit Pediatric Clinic, LLC

516 Quintard Ave, Anniston, AL 36201 -- Phone 256-741-9799 Fax 256-741-9795
 4441 Hwy 431 Ste 1, Roanoke, AL 36274 -- Phone 334-863-2553 Fax 334-863-2558
 2468 Moody Parkway, Moody, AL 35004 - Phone 205-640-1200 Fax 205-640-1005

PATIENT INFORMATION

Patient Name		Gender Male or Female	Patient's Date of Birth	
Mailing Address		City/State/Zip		
Home Phone	Cell Phone	Social Security Number		
Patient Language English - Spanish - Other	Ethnicity Hispanic - Non Hispanic - Other	Patient Race Caucasian - African American - Hispanic - Asian - Other _____		
Email Address		Preferred Method of Communication Home Phone - Email - Cell Phone - Work Phone		
Mother's Name		Mother's Date of Birth	Legal Guardian Yes or No	Phone Number
Mother's Employer	Employer Phone	Mother's Social Security Number		
Father's Name		Father's Date of Birth	Legal Guardian Yes or No	Phone Number
Father's Employer	Employer Phone	Father's Social Security Number		

INSURANCE INFORMATION

Primary Insurance Carrier	Policy Holder's Name	Date of Birth
Insured ID or Contract Number	Group Number	
Secondary Insurance Carrier	Policy Holder's Name	Date of Birth
Insured ID or Contract Number	Group Number	

Please give the receptionist your insurance card and photo ID along with this form as soon as you have completed all sections. Thank You!!!

I understand that Purohit Pediatric Clinic, LLC will bill my insurance company for services rendered to me. The billing of my insurance is a courtesy provided by Purohit Pediatric Clinic, LLC and I understand and agree that I am financially responsible for all charges that are incurred when services are rendered.

Guardian Signature	Date	Relationship
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Purohit Pediatric Clinic, LLC

Patient Agreement for Communications

I understand that as part of my health care Purohit Pediatric Clinic, LLC will need to contact me from time to time for the purposes of reminding me of an appointment, relaying the results of a test, advising me of special precautions and measures that I need to follow prior to a procedure, to follow-up after a procedure, etc. I hereby authorize Purohit Pediatric Clinic, LLC to contact me in the following ways:

_____ Home Phone Number: _____ Message: Yes or No
_____ Cell Phone Number: _____ Message: Yes or No
_____ Office Phone Number: _____ Message: Yes or No
_____ Email Address: _____

I authorize Purohit Pediatric Clinic, LLC to speak with the following person/s and release information on my behalf. (These people will serve as emergency contacts and will be authorized to bring your child in for medical care.)

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

I understand that Purohit Pediatric Clinic, LLC will use the minimum necessary information needed when they communicate with me indirectly. I understand that I can revoke or amend this agreement at any time. Any revocation or change will not apply to communications already complete.

Date _____ Patient's Name _____

Signature of Patient or Authorized Party _____

Relationship to Patient _____

Purohit Pediatric Clinic, LLC

Acknowledgement of Receipt of Privacy Practices

I, _____ have received a copy of Purohit Pediatric Clinic, LLC Notice of Privacy Practices.

Patient's Name _____

Signature of Patient or Authorized Party _____

Relationship to Patient _____

Date _____

OFFICE USE ONLY

On _____ 20____ at _____ (AM / PM) we made a good faith attempt to obtain a written acknowledgement or receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because of the following reasons:

_____ Patient refused to sign

_____ Communication barriers prevented obtaining a receipt

_____ An emergency prevented obtaining a receipt

_____ Other: _____