Alan D. Glassman M.D., P.C.
Pediatric and Adolescent Medicine

Date Completed_____
(This form must be completed annually)

Patient Intake/Registration Information

Please Print
Full Name: _____Name child goes by: _____

Male □ or Female □ Date of Birth: _____ School/Daycare: _____
Ethnicity (check one): □ Hispanic/Latino □ Not Hispanic/Latino
Race (check one): □African American □Asian □Native American □Pacific Islander □White □Other
Siblings: _____ Date of Birth: _____
_____ Date of Birth: _____
_____ Date of Birth: _____
_____ Date of Birth: _____

Parents are:
□ Married
□ Divorced
□ Single Parent

Child lives with:
□ Mother
□ Father
□ Other _____

Mother: _____ D.O.B._____

Mother's Maiden Name: _____

Address: _____City_____County_____Zip_____

Home Phone: _____ ( ) Email: _____
Cell Phone: _____ ( )
Work Phone: _____ ( ) Employer: _____
Please check (√) preferred/primary telephone number

Father: _____ D.O.B._____

Address: _____City_____County_____Zip_____

Home Phone: _____ ( ) Email: _____
Cell Phone: _____ ( )
Work Phone: _____ ( ) Employer: _____
Please check (√) preferred/primary telephone number

EMERGENCY CONTACT INFO: Please list individual(s) living outside your home that may be contacted in case of emergency.

_____
Name Phone Relationship

_____
Name Phone Relationship

Is the individual listed above authorized to bring your child for medical care? YES NOT (CIRCLE ONE)

Assignment of benefits: I authorize payment of medical benefits directly to the physician, realizing that I am responsible to pay all non-covered service, applicable co-pays and deductible amounts. I authorize the release of pertinent information to insurance carriers. Any insurance payments which come to me will be immediately forwarded to the physician's office.

Responsible Party: _____ Date: _____

******PLEASE TURN THIS FORM OVER TO COMPLETE THE BACK******

Office Policies

- All co-pays and deductible amounts must be paid at time of service.
- We accept cash/checks/debit cards/Visa/MasterCard/Discover.
- All returned checks are subject to a $30.00 service charge.
- In the event that we do not accept your insurance, payment is expected in full at the time of service unless arrangements are made in advance with our billing department.
- **It is your responsibility to understand your insurance policy and coverage limits. We strongly advise you to be familiar with your policy. It is your responsibility to notify us immediately of any change in your insurance, address or phone numbers.**
- All insurance cards must be presented at EVERY visit. If your insurance benefits cannot be verified you will be expected to pay in full at the time of service.
- We require an annual update of your INTAKE and CONSENT FOR TREATMENT forms.
- A 48-hour notice is required for all prescription refills, referrals, shot records, and other procedures/paperwork.
- If you are 15 minutes late for your appointment you will have to wait and be worked back into the schedule for that day. If you are late for a wellness/check-up exam we will re-schedule your appointment for a later time and/or date.
- Please notify us in advance if you cannot keep your appointment. A $50.00 no-show fee will apply. **Repeated missed appointments may result in dismissal from the practice.**
- We provide one complimentary copy of medical records to the patient or third party with a signed medical records release form. All subsequent copies are $25.00.
- We see patients by appointment only. We cannot accommodate walk-ins.

CONSENT FOR TREATMENT

By signing below I authorize Alan D. Glassman, M.D., P.C. and such assistants as they may designate to carry out diagnostic procedures and test to better diagnose my child's condition(s) and to administer such treatments and medications as indicated. Further, I understand that the above-mentioned policies are to provide efficient and equitable care to all patients. By signing below I agree to observe the office policies and understand that they may change without notice to allow for proper and expedient care to all patients and families.

_____DATE:_____

(Parent or Guardian if Minor)

PRIVACY NOTICE

Alan D. Glassman, M.D., P.C. considers all protected health information (PHI) confidential and as such will disclose only the information that is necessary to carry out treatments, insure payment or health care operation. Please reference our NOTICE OF PRIVACY PRACTICES for more information on potential uses and disclosures of PHI. You may review our NOTICE OF PRIVACY PRACTICES that is posted in our waiting area. Terms of our privacy practices may change and a revised NOTICE OF PRIVACY PRACTICES will be posted for review. You have a right to restrict how your PHI is used. We are not required to agree to the requested restriction; however, if we agree to a restriction it is binding. You have a right to revoke consent in writing, except to the extent that we have taken action in reliance on it. By signing below I understand and accept the above listed policies, consents, and notices:

_____ DATE: _____

(Parent or Guardian If Minor)