Date: _____

Please Circle

Primary: Dr. Storch Smith/Abramowitz/Nussbaum

Family Information

Mother/Guardian: _____ **DOB:** _____

Father/Guardian: _____ **DOB**: _____

Home Address: _____

Street: _____

Town: _____ **State:** _____ **Zip**:_____

Cell: _____ **Home Phone**: _____

Email Address: _____

Billing Address if Different than Home: _____

Children's Names:

1. _____ DOB: _____M/F
2. _____ DOB:_____ M/F
3. _____ DOB: _____M/F
4. _____ DOB: _____M/F

INSURANCE CARDS MUST BE PRESENTED AT EACH VISIT

Primary Insurance _____ **EFFECTIVE DATE** _____

Policy Holders Name _____ **DOB** _____

ID Number _____ **Group Number** _____

Employer Name _____

All professional services rendered are billable to insurance. All efforts to bill claims to your insurance will be made. However, the guarantor is responsible for charges if correct insurance is not given within the timely filing limits as set

forth by the individual's insurance company. All co-pays are due at time of service. Per the agreement with your insurance, you will be billed for coinsurance or deductible balances. Payment is due upon receipt of our statement unless alternate payment arrangements are made with our billing manager.

Insurance Authorization and Assignment

I request that payment authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to Connecticut Pediatric Partnership, LLC. For any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If Item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown in Medicare/Other Insurance Company as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charged determination of the Medicare/Other Insurance Company.

Signature _____ Relationship_____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ hereby acknowledge that **BAY STREET PEDIATRICS** has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me make be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact 203-834-2436.

I also understand that I am entitled to receive updates upon request if Bay Street Pediatrics amends or changes its Notice of Privacy Practices in a material way.

_____ _____

Signature Relationship to Patient, if signed by someone other than patient

Date _____

THIS SECTION IS TO BE COMPLETED BY **BAY STREET PEDIATRICS** IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

( ) Patient declined to sign this Written Acknowledgement.

( ) Other (specify): _____

_____ Date: _____

Name & Title of Employee