# AMBLER PEDIATRICS

## Patient Demographic Form

### PATIENT INFORMATION

**LAST NAME:** **SUFFIX:** ☐ Jr ☐ III ☐ IV

**FIRST NAME:** **DATE OF BIRTH:**

**MIDDLE NAME:** **NICKNAME:** **BIRTH GENDER:** ☐ Male ☐ Female

**STREET ADDRESS:**

**APT #:** **CITY:** **STATE:** **ZIP:**

**RACE:** ☐ African American ☐ Asian ☐ Caucasian ☐ Other:

**ETHNICITY:** ☐ Hispanic ☐ Non-Hispanic **PRIMARY SPOKEN LANGUAGE (Select ONE Only):** ☐ English ☐ Spanish ☐ Other:

**SIBLINGS:** Full Name: DOB:

Full Name: DOB:

Full Name: DOB:

### PARENT/LEGAL GUARDIAN

**LAST NAME:** **FIRST NAME:** **SUFFIX:**

**DOB:** **HOME # (list only if used):** **CELL #:**

**E-Mail:**

**RELATIONSHIP TO PATIENT:** ☐ Mother ☐ Father ☐ Other: **PRIMARY CONTACT?** ☐ Yes ☐ No

**MARITAL STATUS:** **DO YOU LIVE WITH PATIENT:** ☐ No (Please Give Your Home Address Below) ☐ Yes (skip)

**STREET ADDRESS:** **APT #:**

**CITY:** **STATE:** **ZIP:**

**SIGNATURE:** **TODAY'S DATE:**

### PARENT/LEGAL GUARDIAN #2

**LAST NAME:** **FIRST NAME:** **SUFFIX:**

**DOB:** **HOME # (list only if used):** **CELL #:**

**E-Mail:**

**RELATIONSHIP TO PATIENT:** ☐ Mother ☐ Father ☐ Other: **PRIMARY CONTACT?** ☐ Yes ☐ No

**MARITAL STATUS:** **DO YOU LIVE WITH PATIENT:** ☐ No (Please Give Your Home Address Below) ☐ Yes (skip)

**STREET ADDRESS:** **APT #:**

**CITY:** **STATE:** **ZIP:**

**SIGNATURE:** **TODAY'S DATE:**

# AMBLER PEDIATRICS
602 S. BETHLEHEM PIKE, AMBLER, PA 19002

**OTHER PERSONS AUTHORIZED TO ACCOMPANY PATIENTS DURING VISITS (if applicable)** ***(If you give permission for them to authorize vaccine administration, please indicate below)***

**First & last name** _____ ***vaccine- YES*** ☐ **Relationship to patient**_____

**First & last name** _____ ***vaccine- YES*** ☐ **Relationship to patient**_____

## FINANCIAL RESPONSIBILITY

I/We, _____ am/are financially responsible for minor patient(s)
(parents/guardians)

_____. We hereby authorize my child's insurance company to pay the
(patient's name)

proceeds of any benefits due me exactly to **Ambler Pediatrics.** We acknowledge and understand that we are responsible for payment for all the services rendered to any member of our family.

Although we have requested the doctor to bill the child's insurance company on our behalf, we clearly understand that it is still our responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of a bill is not paid by the child's insurance company, we further agree to make arrangements for prompt payment of the bill.

## MEDICAL RELEASE AUTHORIZATION (must be signed by both parents/guardians)

I authorize release of my child's records to his/her insurance company, if information is requested with regards to processing claims. I certify that the information I furnish is true and correct. I know it is a crime to fill this form with facts I know are false or leave out facts I know are important.

_____ Mother / Father / Other _____
**Signature- Parent/Guardian #1** **Relationship to Patient** **Today's Date**

_____ Mother / Father / Other _____
**Signature- Parent/Guardian #2** **Relationship to Patient** **Today's Date**

**AMBLER PEDIATRICS, P.C.**
602 S. BETHLEHEM PIKE
AMBLER, PA 19002
(215) 643-7771

# Notice of Privacy Practices
# Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

# Amber Pediatrics

## Consent to Leave Messages on Voice Mail, Answering Machines or with Family Members

Patient name(s) _____ Date of Birth _____

At Amber Pediatrics, we understand that communication is an important part of the patient/health care provider relationship. In order to relay important information to our patients' guardians in a timely manner, we may often need to leave messages on voice mail, answering machines or with family members:

***Please provide the telephone numbers where we may contact you:***

_____ (HOME) _____ (WORK) _____ (MOBILE)

### Detailed Voice Mail and Answering Machines Messages

In some cases when we are unable to speak with you directly, we may need to leave a voice mail or answering machines message with detailed information about your child's condition or treatment (such as the results of tests or the scheduling or procedures). You should be aware that other individuals who have access to your voice mail or answering machine could hear these messages. At home this may mean that other members of your family could hear these messages. At work it may mean that your employer could hear these messages.

***Please tell us at which numbers we MAY leave a DETAILED voice mail message:***

☐ Home ☐ Work ☐ Mobile

☐ None, do not leave detailed messages on my voice mail or answering machine.

### Messages with Family Members or Others Who Answer Your Home Phone

We may also need to leave messages with detailed information about your child's condition or treatment, such as the results of tests or the scheduling of procedures, with family members, or others who answer your home telephone.

***Please tell us if we may leave DETAILED messages with individuals who answer your home telephone, please indicate below:***

☐ Yes you may leave DETAILED MESSAGES with anyone who answers my home telephone.

☐ No, Please DO NOT leave DETAILED MESSAGES with anyone who answers my home phone.

***My signature below indicates I have read and understand the above notice regarding consent to leave detailed messages.***

Print name of parent/guardian _____ Parent/Guardian Signature _____ Today's Date _____

Relationship to Patient _____