SMALL WORLD PEDIATRICS

332 S. Orchard Springs Dr. Ste 150 Pueblo West, CO 81007

FOSTER PATIENT INFORMATION

Patient name:_____ **Date of birth:**_____ **Sex:**_____

Street:_____ **City/State:**_____ **Zip:**_____

Phone:_____ **Social Security Number:**_____

Mailing address if different from above:_____

City/State:_____ **Zip:**_____

GUARDIAN(S) INFORMATION

Guardian(s) name(s):_____

Daytime phone:_____ **Evening phone:**_____

Emergency notification:_____ **Phone:**_____

Relationship:_____ **Other phone:**_____

INSURANCE INFORMATION

Primary Insurance:_____ **ID#:**_____

AUTHORIZATION AND RELEASE

For all insurance plans with which Small World Pediatrics, L.L.C. has a contractual obligation, I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my dependant during the period of such care to third-party payors and/or other health practitioners as needed for proper medical care. For more information please refer to our *Notice of Privacy* Practices available in our office.

In consideration of all services rendered, I hereby assign and transfer to Small World Pediatrics, L.L.C. any benefits payable to or for me under hospitalization, sickness or accident coverage, to include major medical or managed care plans for the payment of such services rendered.

I understand and agree that, it is* my *responsibility to provide Small World Pediatrics, L.L.C. with up-to-date billing and insurance information at each visit and should failure to do* so *result in denial* of *payment* of a *claim for services, I will be responsible for that claim.
And, I agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered, and legal and collection fees accrued.

A photocopy of these assignments shall be as valid as the original.

PATIENT (please print)_____ D.O.B._____

NAME OF PARENT/GUARDIAN_____

SIGNATURE OF PARENT/GUARDIAN_____ DATE _____