Corpus Christi Pediatrics **Patient Privacy Information Form** Date ______________

## A. Patient Information

| Children(s) Name | Sex | Birthdate | SSN | Account Number |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## B. Patient/Guardian Info

Responsible Person ______________________________

Email Address ______________________ Marital Status ______________

Home Address ______________________ Phone ______________

City ______________ State __________ Zip Code ______________

Parent #1 Name ______________ SSN __________ DOB __________

Occupation/Employer ______________________ Phone ______________

Parent #2 Name ______________ SSN __________ DOB __________

Occupation/Employer ______________________ Phone ______________



CONTINUED ON THE NEXT PAGE >

## C. Background

Race: ☐ Hispanic ☐ Black ☐ Asian ☐ White ☐ Native American ☐ Mixed

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Preferred Language: ☐ English ☐ Spanish ☐ Other

## D. Emergency Contact Info

In the event of an emergency, who should we contact? Put the name of someone not living with you:

Name ______________________________ Relationship ______________

Address ______________________________________________

City ________________ State __________ Zip Code ______________

Home Phone ____________ Cell Phone ____________ Work Phone ____________

## E. Primary Insurance Info

Insurance Name ______________________________ Phone ______________

Claims Address ______________________________________________

Name of Insured ______________________________ DOB ______________

Identification No. ____________________ Group No. ______________________

Employer ____________________ Relation to Patient ____________________

Copay Amount $__________ Effective Date ____________ Temination Date ____________



CONTINUED ON THE NEXT PAGE >

## 1. Release of Patient's Medical Information

I authorize Corpus Christi Pediatrics (Dr. Torres and Dr. Horn) to release information on my child to include the diagnosis and records relative to treatment and examination to anyone necessary to process my child's medical claims.

## 2. Reproduction of Medical Records to Patient/Parent, Another Physician, an Insurance Company, or Any other Person(s)/Entity with Parental Authorization.

There is a fee for the reproduction of medical records in accordance with limits set by the Texas State Board of Medical Examiners. The fee is $25 for the first 20 pages and $0.50 for each page thereafter. Patients can receive copies of their medical records or can request, in writing, to have the copies forwarded to another designee, such as a physician, attorney, or relative.

## 3. Assignment of Insurance Payments

I, hereby, assign and authorize payment of insurance benefits to be made directly to Corpus Christi Pediatrics (Dr. Torres and Dr. Horn), otherwise payable to me for the services rendered to my dependent. I understand that I am financially responsible for the charges not covered by my insurance company (such as patient's coverage terminated and no cobra coverage, preventive benefits have reached the limit, patient not added to the insurance plan, etc.).

## 4. Services Not Covered by My Insurance

I understand that the services or items that I have requested to be provided at the time of visit may not be considered by my insurance plan as being reasonably and medically necessary for my child(ren)'s care, and therefore, may not be covered. I also understand that I am responsible for payment of these services and/or items I have requested and received if not covered by my insurance company.

I have read and understand paragraphs 1 through 4 above, and I agree to the terms, conditions, and my responsibility to Corpus Christi Pediatrics (Dr. Torres and Dr. Horn), relating to my child(ren)'s medical care.

Signature of Parent/Legal Guardian ______________________ Date ______________________

Print Name of Parent/Legal Guardian ______________________ Relationship to Child ______________________