Welcome to Big Apple Pediatrics!

Today's date _____

We strive to give you competent and compassionate pediatric medical care at each visit.

☐ ***Mother*** ☐ ***Guardian***

Name _____

Home phone _____

Work phone _____

Cell phone _____

Email address _____

☐ ***Father*** ☐ ***Guardian***

Name _____

Home phone _____

Work phone _____

Cell phone _____

Email address _____

Your Child

Child's name _____

Sex ____ Age ____

Birthdate _____

Child's Home Address _____

_____

Phone number _____

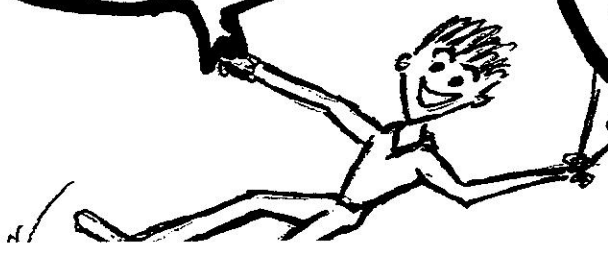
Insured under whom? _____

Emergency Contact

Name _____

Relationship _____

Phone _____



Primary Insurance

Insured's Name _____

Relationship _____

Birthdate _____

Employer _____

Occupation _____

Insurance Company _____

Ins. Co. Address _____

City, State, Zip _____

Group # _____

Policy # _____

Copay _____

Secondary Insurance

Insured's Name _____

Relationship _____

Birthday _____

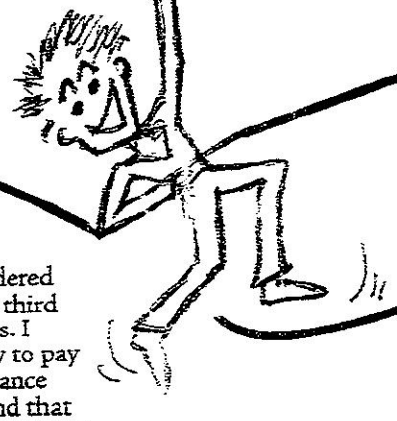
Soc. Sec # _____

Insurance company _____

Group # _____

Policy # _____

Copay _____



Authorization and Release

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payors and/or other heath practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing a late charge of 1.5% on the balance th unpaid and owed will be assessed each month (if allowed by law). I realize th failure to keep this account current m result in you being unable to provide additional services except for emerger or where there is prepayment for additional services. In the case of defa on payment of the account, I agree to collection costs and reasonable attorn fees incurred in attempting to collect

Big Apple Pediatrics
Cathy Ward, MD
315 West 70th Street, #1K
New York, NY 10023

Patient Name: x_____

RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

DATE: _____/_____/_____

The *Notice of Privacy Practices* describes how "Protected Health Information" about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Big Apple Pediatrics is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our pediatric office, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our office. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

x _____
Signature of Patient/Health Care Agent/Guardian/Relative
(This signature indicates having received a copy of the Notice of Privacy Practices).

[ ] Patient is unable to sign due to medical reasons.

[ ] Patient refuses to sign.

[ ] Other (Please explain) _____

This acknowledgement form will become part of your permanent medical record.