Pediatric Associates of Farmington, LLC. 200 Mountain Road, Farmington, CT 06032 **Tel. (860) 676-9000**
PLEASE PRINT **Fax: (860) 676-1541**

To be filled out by current patients when they turn 18 years of age.

Name: _____ Birthdate: _____ SocSec#: _____
(First) (Last)
Address: _____

Phone: Home:_____ Cell: _____ Fax: _____ Email address: _____

Student: FT / PT College: _____

Primary Care Physician: **if not in this office**. _____ Tel. No.: _____ Pharmacy Name & Tel. No.: _____

Insurance Information **(Please present your insurance cards to the receptionist at every visit)**

First Insurance:

Name of Insurance Co: _____

Name of Insurance Co: _____

ID#: _____ Group #: _____

Name of Insured: _____ Birthdate: _____

Soc Sec #: _____ Relationship to Insured: _____

Second Insurance: I do not have a secondary insurance: _____
Initial

Name of Insurance Co: _____

Name of Insurance Co: _____

ID#: _____ Group #: _____

Name of Insured: _____

Soc Sec #: _____ Relationship to Insured: _____

ASSIGNMENT AND RELEASE AND AUTHORIZATION FOR CARE

I, the undersigned, assign directly to Pediatric Associates of Farmington, L.L.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I give permission for the staff of Pediatric Associates of Farmington, L.L.C. / Dr. Deepa Limaye / Lisa Petricca, PA-C, to provide any necessary medical care.

Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND PRIVACY and PERMISSION

Please consider this a request for me to exercise my rights under Federal and State laws by requesting only the following people to communicate in every way any confidential communication about my protected health information (PHI) with the provider and / or staff. This form remains in effect as long as I do not make any changes.

Name: _____ Relationship to me: _____

Name: _____ Relationship to me: _____

Name: _____ Relationship to me: _____

Name: _____ Relationship to me: _____

Signature:_____ Date: _____

RESTRICTIONS QUESTIONNAIRE

May we send statements and reminder cards to address in the Registration sheet?	Yes	No
If no, what address should be used ?_____	Yes	No
May we contact you at home or on the cell phone.?	Yes	No
If not to both of the above, which number should we call? _____	Yes	No
May we leave messages (including laboratory results) on your answering machine?	Yes	No
May we send you a fax? If yes, Fax No. _____	Yes	No
May we contact you via email? If yes, Email address _____	Yes	No

Name: _____ Signature: _____ Date: _____

For restrictions to your protected health information (PHI) other than noted above, please submit your request to the Compliance/Privacy Officer utilizing our "Restriction of Use or Disclosure of Protected Health Information (PHI) Form."

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PLEASE PRINT

To make it easier for the providers to concentrate on your, we ask you to review these policies and cooperate with us in ensuring the best care.

Thank you for understanding and please let us know if you have any questions

1. **AT EVERY VISIT**: Please bring the insurance card, your photo-ID and any payment/co-pay applicable at each visit. **Federal trade commission identity theft: 'RED FLAGS RULE': We have to check photo identification at every office visit to comply with this rule.**

2. **APPOINTMENTS:** please make your next physical exam or follow up appointment before you leave.

3. **FLU VACCINE**: Please call us in September to schedule your flu vaccine.

4. **CALL REMINDERS:** A courtesy call is given prior to the appointment but we expect the caregivers to make note of their appointments.

5. **FAILURE TO KEEP APPOINTMENTS**:
a. A fee of $100 will be charged for any missed appointments or for failure to cancel the appointment 24 hours prior to the appointment.
b. We shall be unable to schedule any more appointments if either the initial appointment or more than three appointments are missed.

6. **CO-PAYS:** All payments are expected at the time of the visit. We will be charging an administrative fee of $5.00 if asked to bill.

7. **RETURNED CHECKS**: A fee of $25.00 will be charged for every returned check.

8. **PRESCRIPTION REFILLS AND FORMS**: Please give us 24-48 hours. Forms not requested at the annual physical exam will be charged an administrative fee of $5.00 each.

9. **QUESTIONS AT THE VISIT**: If you are here for a specific visit such as a vaccine, please understand that any concern expressed and addressed has to be documented as an office visit. Please let us know earlier if you have any other concerns besides the vaccine administration.

10. **ACCOMPANYING CHILDREN:** Please let us know when you come, if the accompanying child(ren) also need(s) to be seen so we can inform you if it is possible without inconveniencing the next patient.

11. ELECTRONIC DEVICES: Please do not use any electronic devices while in the office. Our patients and providers need your full attention and we request all to respect that.

The policies written above have been reviewed and understood.
Date: _____
Signature and name of legal guardian of the child(ren) listed on registration sheet: _____

_____