West 11th Street Pediatric Associates, LLP

Genevieve Ferrier, M.D., F.A.A.P.
Lori Rosello, M.D, F.A.A.P.
Alessandra Zullo, M.D, F.A.A.P.

Today's Date______________________

NEW PATIENT INFORMATION

1. Patient's Name____ First Last

Date of Birth__________________ Sex______________ SS#__________________________

2. Patient's Name____ First Last

Date of Birth__________________ Sex______________ SS#__________________________

3. Patient's Name____ First Last

Date of Birth__________________ Sex______________ SS#__________________________

➢ Address__________________________ Apt#__________ City____________________

State________________ Zip Code___________ Home Phone#________________________

❖ Father's/Partner's Name____

Occupation_____________________________ Work Phone#__________________________

Cell Phone_____________________________ E-mail________________________________

Address If Different from Patient's Address______________________________________

❖ Mother's/Partner's Name____

Occupation_____________________________ Work Phone#__________________________

Cell Phone_____________________________ E-mail________________________________

Address If Different from Patient's Address______________________________________

Pharmacy Name__________________________ Phone#_______________________________

Pharmacy Address (including zip code)____

Emergency Contact (not parent)________________________________ relation____________

Cell Phone_____________________________ home phone___________________________

Insurance Plan______________________________________ Co-pay amount $____________

Policy ID/Member/Subscriber#_________________________________ Group#____________

Primary Insureds's Name____

Primary Insured's DOB__________________________ Insured's SSN__________________

Secondary insurance Name and policy #____

I,____(parent or guardian), have received a copy of West 11th Street Pediatric Associates, LLP's Notice of Privacy Practice.

46 W. 11 St. NY, NY 10011 • (212) 529-4330 • Fax (212) 598-0285

Financial Policy

Payment for service is required at the time of your child's visit and includes the copay and any deductible, prior balance or form fees. We require payment in full if we do not accept your insurance. (You will be given a receipt to submit to your insurance company if you have out of network coverage).
Initial ____________

If you have HMO insurance, it is your responsibility to notify your insurance plan that you have chosen a doctor in our practice to be your child's Primary Care Provider. If you fail to do this, all medical service fees will be your responsibility.
Initial____________

It is your responsibility to notify our office of any change in your insurance coverage or contact information. If you fail to do this, all medical service fees will be your responsibility.
Initial_____________

I understand that West 11th Street Pediatric Associates, LLP will charge me $50 for any missed appointment which was not canceled at least 24 hours in advance.
Initial____________

Payment agreement

I, the undersigned, do hereby expressly guarantee payment in full and within 30 days of any and all charges for medical services for____ (child's name)

West 11th Street Pediatric Associates, LLP commencing ________________ 20_______.

____ _________________________________
(parent signature) (printed name)

Credit Card Payment Authorization

We request that your current credit card information be kept on file with us. We will email you a receipt.

_____I authorize automatic use of my card for all outstanding balances, including co-pays, form fees and deductibles.

Name on card: ____Card name: ________________

Card number: ____ Expiration date: __________

Zip code: ___________________ Security Code(CSV) _____________

Signature: ____

NYC Department of Health and Mental Hygiene
Immunization Program
Vaccines For Children Program

ELIGIBILITY SCREENING FORM

Provider Name: ______________________________ **Date of Screening:** _____/_____/_______
MM DD YYYY

HEALTH CARE PROVIDER: A record must be kept in the healthcare provider's office that reflects the status of all children up to their 19th birthday who receive immunization through the NYC VFC program. The record may be completed by the **parent, guardian, individual of record, or healthcare provider**. The same record may be used for all subsequent visits as long as the child's health insurance status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

PATIENT INFORMATION:

Child/Patient Date of Birth: _____/_____/_________
MM DD YYYY

______________________ ______________________ ______
Child/Patient Last Name First Name M.I

______________________ ______________________ ______
Parent/Guardian's Last Name First Name M.I

Check the appropriate eligibility category line below for children (up to their 19th birthday) who receive publicly purchased vaccine in New York.

1. Medicaid/Medicaid managed care enrolled ______________ Date
2. Uninsured (no insurance) ______________ Date
3. Underinsured (insurance does not cover vaccines) ______________ Date
4. Native American/Alaskan Native ______________ Date
5. Not Eligible (insurance covers immunization) ______________ Date
6. Child Health Plus B (CHPlus B) ______________ Date

EXPLANATIONS/INSTRUCTIONS FOR USE OF CATEGORIES ON BACK

West 11th Street Pediatric Associates, LLP

46 West 11th Street
New York, NY 10011

HIPPA Consent Form

Effective From:

This consent form allows West 11th Street Pediatric Associates, LLP to use and disclose information about me protected under Health insurance portability and accountability act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

West 11th Street Pediatric Associates, LLP has provided me with a notice of privacy practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing the forming accordance with my right to review its practices before signing consent.

I understand that the terms of notice of privacy practices may change and that I may obtain revised notices by mail or by an update on our website.

I understand that I have right to request, now and in the future, how protected heath information is used or disclosed to carry out treatment, payment and health care operations. I understand that while West 11th Street Pediatric Associates, LLP is not required to agree to my requested restrictions, if does agree, it is bound by that agreement.

I understand that at any time the right to revoke this consent provided that I do so in writing, but that the service may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information.

I understand the West 11th Street Pediatric Associates, LLP may refuse me further service if I revoke the consent.

Patient's / Guardian's Signature: **Date:**