



## West 11th Street Pediatric Associates, LLP

Today's Date\_\_\_\_\_

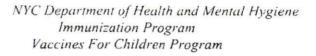
Genevieve Ferrier, M.D., F.A.A.P. Lori Rosello, M.D, F.A.A.P. Alessandra Zullo, M.D, F.A.A.P.

NEW F	PATIENT INFORM	MATION		Alessandra Zullg	
1.	Patient's				
	Name				
	2	First	-10/2	Last	
Date of	f Birth	Sex	SS	#	
2.	Patient's				
	Name				
D - 1	f n'-d-	First	CC	Last	
		sex	55	#	
3.	Patient's				
	Name				
	C D : !	First	C	Last	
Date o	r Birtn	Sex	55	#	
> Δι	ldress		Apt#	City	
	Jule33	7in Code	Home Pho	ne#	
Jiaic_		zip code	none me	THE	
❖ Fat	ther's/Partner's N	ame			
Occupa	ation		Work Phone	#	
	one		E-mail		
Addres	s If Different from	Patient's Address			
❖ M	other's/Partner's	Name			
Occup	ation	variic	Work Phone	#	
Cell Ph	one		E-mail		
Addi C.	os ii biiiciciic iioii				
Pharm	acy Name		Phone#		
	acy / iaa. coo (e.a				
Emerg	ency Contact (not	parent)		relation	
			home phone		
CC	.0110				
Insura	nce Plan			Co-pay amount \$	
			Group#		
				Insured's SSN	
Drima	y Insured's DOB		Insured		
				33311	
Second	uary insurance iva	me and policy #			
	11 <sup>th</sup> Street Pediatr		(parent o	or guardian), have received a copy of	

# Financial Policy

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 commencing20							
(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:							







#### **ELIGIBILITY SCREENING FORM**

Provid	ler Name:	Date of Screening:/		
			MM DD YYY	Y
reflects VFC p health health	TH CARE PROVIDER: A record mest the status of all children up to their 19 <sup>th</sup> program. The record may be completed care provider. The same record may be insurance status has not changed. We ary to retain this or a similar record for the care of t	birthday who receive imm by the <b>parent</b> , <b>guardian</b> be used for all subsequent hile verification of responses	nunization through the n, individual of receivisits as long as the consess is not require	ne NY( ord, o child'
PATH	ENT INFORMATION:			
Child/I	Patient Date of Birth:// MM DD YYY	<del>7</del> Y		
Child/	Patient Last Name	First Name	M.	Ī.Ī
Parent	/Guardian's Last Name	First Name		.I
Check who re	the appropriate eligibility category li eceive publicly purchased vaccine in N	ine below for children (u New York.	ap to their 19 <sup>th</sup> birt	hday)
1.	Medicaid/Medicaid managed care enro	olled	Date	
2.	Uninsured (no insurance)	11117	Date	
3.	Underinsured (insurance does not cover	er vaccines)	Date	
4.	Native American/Alaskan Native		Date	
5.	Not Eligible (insurance covers immuni	ization)	Date	
6.	Child Health Plus B (CHPlus B)	Attilian con mile and a second	Date	
			Unit	

EXPLANATIONS/INSTRUCTIONS FOR USE OF CATEGORIES ON BACK

DOH 3835P (Revised 12/2008)

### 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: