Patient Information & Consent/Confidentiality Form

Patient (s)
Last:____________________________ MI_____ First:_________________________DOB:___________ M / F
Last:____________________________ MI_____ First:_________________________ DOB:___________M / F
Last:____________________________ MI_____First:__________________________DOB:___________M / F

Parent/Guardian Information
Relationship to patient:_____________Last:__________________________First:_______________________
DOB:_____________SS#________________Address:____
City___________________State______Zip_________________Primary phone#________________________
Secondary #_________________________Email:_______________@_____________

With whom do the child/children live with? Mom Dad Both or:_____________________
How did you hear about Bee Caves Pediatrics? _______________________________________
Do we have permission to send you appointment reminders via text messaging, email and/or voicemail? ___

Insurance Policy Holder
Relationship to patient____________Last_____________________________First________________________
DOB:_____________SS#________________Address:____
City____________________________State________Zip Code____________Phone#_____________________

Insurance Information
Insurance company:______________________ID/Member #______________________Group#____________
Medical claims address:____________________________________Provider services#___________________

Consent Form
I authorize (with my signature below) the medical providers at Bee Caves Pediatrics to provide my child(ren) with reasonable and proper medical care. I have read & I agree with Bee Caves Pediatrics **Practice Policies** that I am financially responsible for any unpaid deductible and/or co-payments that are due at the time services are rendered. I understand that as a courtesy, all charges will be filed to my insurance company. Charges not payable or non-covered by my insurance are my responsibility. As required by the HIPPA Privacy Regulations, I hereby acknowledge that I have reviewed a current copy of **Notice of Privacy Practice** and understand my rights contained in the notice.
Signature:______________________________________Date:_______________________________________

Confidentiality Form
There are times we will need to communicate with you by telephone. If you are not immediately available at those times, we will need permission to leave detailed messages on your primary phone # concerning your child. Please complete and sign this confidentiality form below so we are clear about your wishes on this matter.

____You **MAY** leave a voicemail with confidential information regarding non-urgent medical issues

____You **MAY NOT** leave a voicemail with confidential information regarding non-urgent medical issues
Signature:_____________________________________Date:____