SINGULAR PEDIATRICS
32 Union Street
Newton, MA 02459

Wanessa Risko, M.D

PATIENT INFORMATION FORM

Patient's Name: _____ Male/Female

Date of Birth: _____ Street Address: _____

City/State: _____ Zip Code_____

Best Contact Phone Number: _____ (work / cell / home)

Alternate Contact Phone Number: _____ (work / cell / home)

Email: _____ (Mother/ Father/ Patient)

Address and Name of Preferred Pharmacy: _____

Siblings:

Name: _____DOB:_____ Name: _____ DOB:_____

Name: _____DOB:_____ Name: _____ DOB:_____

Parent/Guardian that is the Insurance Carrier:

Name: _____

Relationship: _____ DOB:_____

Other Parent/Guardian:

Name: _____

Relationship: _____ DOB:_____

Payment Reasonability Waiver

I authorize Singular Pediatrics to submit claims to my insurance carrier(s) for services that they believe to be "covered services" and to receive payments on my behalf. I understand that I am financially responsible for, and agree to pay for, any services to my children by Singular Pediatrics that are:

- Not covered by my insurance and or
- Denied by my insurance company for ineligibility reasons such as:

My failure to obtain the necessary referral and or authorizations from my insurance carriers, my Primary Care Physician and or referring physicians when required;

- My Primary Care Physician (PCP) selection is incorrect

_____ _____

Signature of Patient/Guardian (if not over 18) Date

Please Sign the Back →

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Acknowledgement of Receipt of Notice of Privacy Practices

In this notice, "you" and "your" are also used to mean and pertain to "you and your child," or your children when appropriate.

The providers (physicians, nurses, MA, nurse practitioners, and administrative staff) at our practice, at the direction of the physicians, may share your health information for treatment, payment, and health care operations.

I understand that my health information may be used for treatment, payment, or healthcare operations purposes, such as:

- Sharing my health information among providers (both inside and outside the practice), on a need-to-know basis, to give me treatment
- Using my health information for billing purposes, including giving referrals to specialists, when necessary and appropriate
- Sharing my health information with health insurance companies, government agencies, or other payers that request information related to benefits determinations, claims filed for visits or admission, and other billing matters
- Using my health information for healthcare operations, including monitoring the quality of care, audits and surveys, and carrying out other business and administrative activities

I understand that all reasonable efforts will be made to protect the privacy of my health information whether maintained on paper or electronically, and regardless of how it is communicated (paper, email, fax).

I have been given the opportunity to read the Notice of Privacy Practices that outlines in more detail how my health care information is used and shared with others. The Notice of Privacy Practices explained (1) when I need to give further approval for the providers to use my health information or share it outside the practice and (2) when my permission is not needed for provides to use my health information or share it outside the practice (i.e.: required by law, public health inquiries, etc.)

I understand that this practice has reserved the right to change the Notice of Privacy Practices at any time. I may obtain a current copy of the Notice of Privacy Practices by contacting the Privacy Officer or from the practices' website.

My signature below constitutes my acknowledgement that I have been provided a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient/Guardian (if not over 18) Date