



Registration Form

Today's Date: ___/___/___

Last Name & First Name	Sex	Birth Date
_____	M F	___/___/___
_____	M F	___/___/___
_____	M F	___/___/___

Parent Information :

Parent Name: _____ D.O.B: ___/___/___

Address _____
Street City State Zip Code

Cell phone: _____ Home #: _____ Email address: _____

Parent Name: _____ D.O.B: ___/___/___

Address _____
Street City State Zip Code

Cell phone: _____ Home #: _____ Email address: _____

Who has custody of the child/children? _____

Medical Insurance: _____ Policy Holder Name & DOB: _____

Emergency Contacts:

Names & Relationships of others who have permission to bring & are authorized to make medical decisions for your child:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Your Child(ren)'s Race: Ethnicity: Unknown

Asian Caucasian Hawaiian Native/Pacific Islander Black/African American

Hispanic or Latino Not Hispanic or Latino I prefer not to answer

Your preferred language: _____

Signature of parent/guardian: _____ Today Date: _____

TLC PEDIATRICS, LLC

10 Mott Avenue, Suite 2A • Norwalk, Connecticut 06850 • (203) 855-7551 • fax (203) 855-7624 • www.tlcpediatrics.org



AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS FORM

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless insurance coverage is verified, and TLC Pediatrics is a participating provider. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to TLC Pediatrics for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize TLC Pediatrics to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment. This order will remain in effect until revoked by me in writing.

I have requested medical services from TLC Pediatrics on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (cop1 x 200 inhalation canister (ay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

In addition, I hereby authorize TLC Pediatrics to evaluate and treat my child/children as needed.

Child's First & Last Name

Date of Birth

Child's First & Last Name

Date of Birth

Child's First & Last Name

Date of Birth

Date: _____

Signature of parent/guardian:

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & PATIENT RIGHTS

We are required by State and Federal laws, including the HIPAA Rules, to safeguard general and health-related information about you. We have created a Notice of Privacy Practices that explains how your protected health information is handled. The Notice of Privacy Practices is provided to patients (and/or their authorized representatives) when they first become our patient.

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. By signing below, you are only acknowledging that you were offered or received a copy of the Notice of Privacy Practices. You are not making any statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of it.

Acknowledgment

I acknowledge that TLC Pediatrics., LLC has offered or provided me with a copy of its Notice of Privacy Practices & Patient Rights electronically via the secured Patient Portal, which describes how medical information about me may be used and disclosed, and how I can access this information.

- I understand that if I have questions or complaints, I may direct my questions to the Office Manager.
- I also understand that I am entitled to receive updates upon request if TLC Pediatrics., LLC amends or changes its Notice of Privacy Practices in a material way.

Signature of patient or patient's representative

Date

Printed name of patient/patient's representative

Relationship to patient

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