Jesus Burbano, MD, LLC Pediatrics

Patient Information

Last Name _____ Middle Initial _____

First Name _____ Date of Birth (DOB) *MM/DD/CCYY*

Address _____ _____

Apt Number _____ Gender (Circle) Male / Female

City _____ Social Security Number (SSN)

State _____ Zip _____ _____

Contact Information

Landline Phone _____ **Cell Phone** _____

Work Phone _____

Parent / Guardian 1

Last Name _____ First Name _____

Date of Birth _____ SSN _____

Relationship to Patient _____ Employer _____

Address (if different) _____

Parent / Guardian 2

Last Name _____ First Name _____

Date of Birth _____ SSN _____

Relationship to Patient _____ Employer _____

Address (if different) _____

Emergency Contact

Full Name _____ Phone _____

Relationship to Patient _____

Patient Insurance Information *Please provide insurance card.*

Insurance Name _____

Subscriber No _____

Insured's Last Name _____ Insured's First Name _____

Insured's DOB _____ Insured's SSN _____

Patient's Relationship to Insured _____

Group Number _____ Medicaid ID _____

Is patient covered by any other insurance? Yes / No *If yes, please provide secondary insurance information.*

Insurance Name _____

Subscriber No _____

Insured's Last Name _____ Insured's First Name _____

Insured's DOB _____ Insured's SSN _____

Patient's Relationship to Insured _____

Group Number _____ Medicaid ID _____

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Additional Information

Parent Email Address _____

Patient Email (for children over 12) _____

Patient Race _____

Patient Ethnicity (circle) Hispanic or Latino / Not Hispanic or Latino / Refuse to Report

Primary Language _____

Pharmacy Information

Pharmacy Name _____

Any Pharmacy Information *(phone number, street name, zip code, general location)*

_____

Patient Consent

Assignment of Benefits & Release of Information

I certify that I, and/or my dependent(s) have insurance coverage with _____ (insurance company name), and assign directly to **Jesus A. Burbano, MD, LLC** ("Practice") all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all the charges whether or not paid by the insurance company. I authorize the use of my signature on all my insurance submissions.

The Practice may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services.

Disclosure of Information & Patient Rights

I understand that the Practice complies with all federal and local regulations including the Health Insurance Portability and Accountability Act (HIPAA); and that this Consent includes my agreement that the Practice can use private health information for treatment, payment and other purposes as defined in the Notice of Privacy Practices. I agree to the Practice's use of de-identified health information about the patient for appropriately reviewed and approved research and quality improvement activities.

I understand that patient information will still be stored electronically for my provider's records, and that an electronic health summary will be available to other providers through the **Children's IQ Network** (CIQN). I also understand that I have the right to not share (opt out) health information with other providers within the CIQN.

Consent for Services

I understand that the Practice, requires a signed Consent for Services before proceeding with treatment. I hereby give consent to the Practice, its employees and/or contractors to examine and treat the patient.

I understand that:

- Tests and immunizations may be included as part of the examination and treatment;
- I may be required by the Practice's policy to give a separate written consent for some treatments and procedures;
- I have the right to cancel this Consent in writing and/or limit my disclosures. If I notify the Practice in writing to cancel this Consent for Services, the Practice may stop examining and treating my child;
- There are no guarantees regarding outcomes and results of these examinations and treatments.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Print Name of Parent or Legal Guardian Relationship to Patient