Bright Start Pediatrics
where kids shine the brightest

Access our Patient Portal & Facebook through our website
www.brightstart-pediatrics.com

Patient Information

Name _____ **Date of Birth** _____

Preferred Name _____ **Gender Orientation** _____ **Preferred Pronouns** _____

Race/Ethnicity _____ **Preferred Language** _____ **Primary Physician** _____

Preferred Pharmacy: _____ **Pharmacy Phone:** _____

Pharmacy Location: _____

PLEASE LIST ALL OTHER CHILDREN WHO WILL BE PATIENTS AT BRIGHT START PEDIATRICS BELOW:

1. **Name:** _____ **Date of Birth:** _____
2. **Name:** _____ **Date of Birth:** _____
3. **Name:** _____ **Date of Birth:** _____
4. **Name:** _____ **Date of Birth:** _____

Emergency Contacts

Please list at least one emergency contact other than parent/legal guardian

Emergency Contact 1: _____

Relationship: _____ **Phone:** _____

Emergency Contact 2: _____

Relationship: _____ **Phone:** _____

Parent or Guardian Information

PARENT 1: _____ **Date of Birth** _____ **Marital Status:** _____

Address: _____ **Social Security #:** _____

Employer: _____ **Primary Number:** _____ **Email:** _____

PARENT 2: _____ **Date of Birth** _____ **Marital Status:** _____

Address: _____ **Social Security #:** _____

Employer: _____ **Primary Number:** _____ **Email:** _____

****If the parents are separated, at which household do/does the child/children reside?** _____

(Cont.)

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INSURANCE INFORMATION:

Primary Insurance:

Subscriber's Name: _____ Date of Birth: _____ Relationship to Patient: _____

Insurance Carrier: _____ Policy No: _____Group No: _____

Secondary Insurance:

Subscriber's Name: _____Date of Birth: _____ Relationship to Patient: _____

Insurance Carrier: _____ Policy No: _____Group No: _____

Tertiary Insurance:

Subscriber's Name: _____Date of Birth: _____ Relationship to Patient: _____

Insurance Carrier: _____ Policy No: _____Group No: _____

I authorize payment of medical benefits by the insured directly to Bright Start Pediatrics PLLC. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or materials provided to my family member and for any yearly deductible or co-payment amount. I agree to pay all services within 20 days unless a payment plan is negotiated in advance. I authorize Bright Start Pediatrics PLLC to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

TIME _____ ☐ AM ☐ PM **DATE** _____ **Parent/Guardian Signature** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practice Form.

TIME _____ ☐ AM ☐ PM **DATE** _____ **Parent/Guardian Signature** _____

(Cont.)

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AUTHORIZATION FOR SPECIFIC CONFIDENTIAL COMMUNICATIONS

Is it ok to leave a detailed message including medical information on your voicemail?

☐ **No** ☐ **Yes** Phone # _____

I authorize my physician and/or administrative and clinical staff to disclose the following information to: (other than parents)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:

☐ Medical Care / Treatment Level of Information _____

☐ Billing Information

☐ Prescriptions, X-Ray and Lab Results

☐ Other (specify in detail – such as date of service, type of service, level of detail to be released, origin of information etc.) _____

_____

AUTHORIZATION FOR NON-PARENT TO MAKE MEDICAL DECISIONS FOR MINOR CHILD

I authorize the following person (people) to bring my children to Bright Start Pediatrics and make medical decisions for their care. (Please include any Step-Parents.)

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

This authorization shall be in force and effect and will expire one year from the date signed below. I understand that I haver the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: Bright Start Pediatrics PLLC – 1375 W. Green St #3 Hastings, MI 49058. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal law.

TIME _____ ☐ AM ☐ PM **DATE** _____ **Parent/Guardian Signature** _____

REV 7.2022