Commerce Pediatrics SudiptaDhar, M.D.

2900 Union Lake Road, Suite 130, Commerce Twp., MI 48382 Phone (248) 366-0101 Fax (248) 366-0108

Patient Information

Name_____DOB_____ M / F Date_____

Street Address_____City_____Zip_____

Primary Phone ( ) _____ - _____ Alternate Phone ( ) _____ - _____

Parent/Guardian Information

Mother_____DOB_____Phone ( ) _____ - _____

Street Address_____ (SAME AS CHILD)

City_____Zip_____ Alternate Phone ( ) _____ - _____

CUSTODY RESTRICTIONS? YES / NO (EXPLAIN) _____

Father _____DOB_____Phone ( ) _____ - _____

Street Address_____ ☐ (SAME AS CHILD)

City_____Zip_____ Alternate Phone ( ) _____ - _____

CUSTODY RESTRICTIONS? YES / NO (EXPLAIN)) _____

WE ARE REQUIRED TO COLLECT THE FOLLOWING INFORMATION FOR EACH PATIENT:

PREFERRED LANGUAGE:

_____

ETHNICITY:

- ☐ HISPANIC/LATINO
- ☐ NOT HISPANIC/LATINO
- ☐ UNKNOWN
- ☐ DECLINE TO ANSWER

RACE:

- ☐ AMERICAN INDIAN/ALASKAN NATIVE
- ☐ ASIAN
- ☐ BLACK/AFRICAN AMERICAN
- ☐ HAWAIIAN NATIVE/PACIFIC ISLANDER
- ☐ WHITE
- ☐ OTHER_____
- ☐ DECLINE TO ANSWER

_____ _____

(SIGNATURE) (DATE)

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Name_____DOB_____

Parent/Guardian (PLEASE PRINT) _____

Acknowledgement of Receipt of Notice of Privacy Practices/HIPAA

I acknowledge reviewing a copy of the Commerce Pediatric Associates P.C. notice of privacy practices_____ (initials of patient of authorized representative)

Authorization for Release of Medical Records

I _____ authorize the release of medical record information regarding the above named patient to Commerce Pediatrics. The following medical information is subject of this authorization:

___ the entire medical record and history of care

___record of care from _____to present

___other:_____

I understand and agree that the records release may include:

- Alcohol and drug abuse information protected under the regulation in 42 Code of Federal Regulations, Part 2, if any
- Psychological and/or social service information if any
- Information about HIV, AIDS, or ARC protected under MCL 333.5131, or any communicable disease

This authorization is valid for a maximum of two years from the date below or until expressly revoked.

_____ _____

(SIGNATURE) (DATE)

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Patient Name_____

Parent/Guardian (PLEASE PRINT) _____

Acknowledgement of Assignment of Benefits

Our office makes every effort to contact your insurance company and verify your benefits. However, verification of benefits is not a guarantee of payment until claims are submitted and the insurance company reviews all records. If your insurance company denies payments or services are not covered, you will become financially responsible for services.

Please be aware that it is your responsibility to make sure we are in your covered network.

I hereby authorize payment to any physician of Commerce Pediatrics Associates who has treated my dependents for medical services rendered. I understand that I am financially responsible for all services and fees not covered by my insurance.

Parent/Guardian (SIGNATURE) _____ DATE _____