Four Seasons Pediatrics
532 Moe Road
Clifton Park, NY 12065

Today's Date _____________

Patient Information:

Last name: ______________________________ First name _______________________________ Middle initial _______

Address: ____ City ____________________ State ____ zip ___________

Phone ____________________________ DOB _____________ Sex: ________ Patient SS# ____________________

Primary Care Physician ____

Phone number of Primary care physician _________________________________

Insurance Information: Enter policy holder / subscriber information

Policy Holder or responsible party: Last name ____________________ First name __________________ Middle initial ____

Address: If address is the same as patient just write 'same'

Street: ______________________________________ City ___________________________ State ______ zip ___________

DOB: _______________ Sex: ________ Policy Holder SS# _______________________________

Home phone: ___________________________ Work phone __________________________________

Employer: ________________________________ Occupation __________________________________

Name of insurance ___________________________________ Effective date ________________________

Patient's policy # _____________________________________ Group number _______________________

Does your insurance require a copay? ______ if so what is the copay amount _____________________

Please have your insurance card available for scanning. Thank you

I have received a copy of the Four Seasons Pediatrics **Patient Consent for Treatment, Payment and Healthcare Operations,** I understand the responsibilities for me and Four Seasons Pediatrics.
I may revoke my consent in writing except to the extent that the practice has already made disclosures or provided services in reliance upon my prior consent. If I do not sign this consent, I understand that Four Seasons Pediatrics is under no obligation to provide treatment to me.
I authorize the use of my signature for all my insurance submissions and to carry out activities related to treatment, payment and healthcare operations with all my insurance companies. I understand that I am responsible for any fees not covered by my insurance company, unless my insurance company prohibits billing for such services. I authorize payment directly to Four Seasons Pediatrics. I permit a copy of this authorization to be used in place of the original.

________________________________ ________________________________ ______________

Print name | Signature | Date