LOWER FALLS PEDIATRICS

65 Walnut Street, Suite 310, Wellesley, MA 02481
T: 781-772-1527 F: 781-772-1497
Website: www.lowerfallspediatrics.com

**PATIENT INFORMATION**

Today's Date: _____

Patient Name: _____

Date of Birth: _____ Gender: Male/Female

Home Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Name: _____ Cell: _____

Email: _____

Parent/Guardian Name: _____ Cell: _____

Email: _____

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**Insurance Information**

Insurance: _____ Subscriber Number: _____

Name of Subscriber: _____ Date of Birth: _____

Relation to Patient: _____

I authorize release of medical information necessary to process claims for medical benefits. I authorize and direct payments to Lower Falls Pediatrics for services provided. In the event my insurance denies coverage for services provided, I understand that I will be responsible for balances issued via patient statement.

Signature of Parent/Guardian: _____ Date: _____

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# Patient Financial Waiver

Due to the high cost of health care, many patients have elected insurance plans that have less expensive monthly premiums, but higher co-payments and deductibles.

Your visit for a routine physical exam may or may not require a co-pay. If your doctor provides any other service not routinely included in your exam your insurance company may not pay the total amount. In the event this happens you will be billed and be responsible to pay a co-pay or deductible according to the insurance plan you selected. Please call your insurance company directly for specifics regarding your insurance plan.

Telehealth/Virtual Visits:
Regarding the billing of virtual visits and telehealth visits: Please note that virtual visits and phone calls that take place after hours will be billed out as their respective visit types, and this could trigger the collection of a co-pay or deductible from your insurance.

I agree to assume full financial responsibility for any services provided to my child(ren) by Lower Falls Pediatrics. This includes if my insurance company denies payment of my claims for any reason including ineligibility, incorrect primary care provider (PCP) selection, or because the services are not covered by my insurance company.

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Parent or Guardian Name (PRINT): _____

Parent or Guardian Signature: _____

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**HIPAA - ACKNOWLEDGEMENT OF RECEIPT**
**NOTICE OF PRIVACY PRACTICES**

Printed Patient Name: _____

Patient Date of Birth: _____

We at Lower Falls Pediatrics are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____
Signature of patient or patient representative/Guardian/Parent Date

_____
Printed Name of patient or patient representative/Guardian/Parent

_____
Relationship to patient