

Emergency Contact: _____

Address (Mailing): _____

Address (Street): _____

City: _____ State: _____ Zip: _____

Phone: () _____ Cell Phone: () _____

LIST ALL PEOPLE AND RELATIONSHIP TO THE PATIENT THAT MAY BRING THE PATIENT TO OUR OFFICE FOR APPOINTMENTS AND RECEIVE INFORMATION:

| Name | Relationship |
|-------|--------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

If my insurance requires a referral, I will have the Primary Care Provider mail or fax to the office prior to office visit. I am responsible for charges for services rendered without a referral.

I hereby authorize the physicians of Pediatric Pulmonology & Sleep Medicine to release any information acquired in the course of examination or treatment of my child. I agree to pay to Pediatric Pulmonology & Sleep Medicine all charges for services both inpatient and outpatient, which are rendered by Pediatric Pulmonology & Sleep Medicine and for which my child's insurance does not directly pay. I understand that any past due account balances owed to Pediatric Pulmonology & Sleep Medicine may be turned over to a collection agency. I realize this may effect my credit rating and I may be responsible for all collection and legal fees incurred by the practice in the course of collecting my/our outstanding balance.

Parent/Guardian Signature

Date