Mission Care Pediatrics, Inc.

Shikha Garg, M.D., FAAP
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First Name (Child's Name) MI Last Name	**Gender** **M☐ F☐**
Home Address	**Date of birth (Child's)**
City, State, Zip code	**Home Phone Number**
Mother's Name/Legal Guardian & Date of Birth	**Cell Number**
Father's Name/Legal Guardian & Date of Birth	**Cell Number**
Email address and name of person responsible for child's account	**Phone Number**
Emergency Contact (someone other than mom or dad)	**Phone Number**
How did you hear about us?	**Circle one:** **Internet (Google/Yelp)** **Referred by friend** **Friends name:**
Insurance Coverage	**Id Number**
Policy Holder/DOB	**Group Number**

I hereby authorize my child's treatment and payment directly to Mission Care Pediatrics, Inc. Of all insurance benefits otherwise payable to me for services at the time they are rendered. I understand that I am financially responsible for all charges not covered by my insurance carrier for services rendered on my behalf of my dependents. Any "balance due" will be charged to your credit card on file. I authorize the above providers to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature_____Date_____

Mission Care Pediatrics, INC.

Acknowledgement of Receipt of Summary Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health and Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA, providers of healthcare are required to give patients their notice of Privacy Practice for Protected Health Information and make a good faith effort to obtain a written acknowledgement that this notice was received.

Therefore, I (print name of the patient or guardian) _____ acknowledge that Mission Care Pediatrics, INC. has provided a written copy of their summary Notice of Privacy

_____ _____
Name of patient Date

_____
Signature of patient or guardian

For office use only:

Mission Care Pediatrics, INC. has made a good faith attempt to provide above named patient with a copy of our summary Notice of Privacy Practices, but we were not successful for the following reason:

_____
_____
_____
_____

_____ _____
Name of patient Date

_____
Signature

_____