



**Sonia Gidwani, MD, PLLC**  
 Board Certified Pediatrician  
 Child and Adolescent Wellness, Pediatric  
 Weight Management, Pediatric Acupuncture

**our kids' MD**

135 West 70th Street,  
 New York, NY 10023.  
 Phone: 212 496 KIDS  
 info@ourkidsmd.com  
 http://www.ourkidsmd.com

<p><b>Patient Information &amp; Benefits Record Release</b>          form page 1 of 2</p>	<p>Instructions: Complete all appropriate fields. Please confirm all numbers and bring verification of health insurance with you to your first appointment.</p>
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**PATIENT INFORMATION**

Please list all children's names (last, first) & birth dates

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Pager: \_\_\_\_\_

Primary Email (one that is checked frequently): \_\_\_\_\_

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# : \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Responsibility Party : \_\_\_\_\_  
Person responsible for paying your medical bills, other than Ins. Co.

Emergency Contact : \_\_\_\_\_ Phone : \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Claims Address: \_\_\_\_\_  
 \_\_\_\_\_

Membership #: \_\_\_\_\_ Co-Pay: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Relationship: [ ]-Self [ ]-Spouse [ ]-Child

Secondary Insurance: \_\_\_\_\_

Claims Address: \_\_\_\_\_  
 \_\_\_\_\_

Membership #: \_\_\_\_\_ Co-Pay: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Relationship: [ ]-Self [ ]-Spouse [ ]-Child

PLEASE READ AND SIGN REVERSE SIDE FOR GUARANTOR LIABILITY & OFFICE POLICES.



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Patient Information & Benefits Record Release form page 2 of 2

## PATIENT BENEFITS/RECORD RELEASE

Your Name: \_\_\_\_\_

Please Print

### AUTHORIZATION

I authorize Our Kids MD, L.L.C. to release medical information as it is necessary to bill my insurance carrier. In addition, I authorize my insurance carrier to release payments of insurance benefits directive to Our Kids MD.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### CO-PAYS

All co-pays will be due before the doctor sees you. Co-pays are also collected even when visits are for immunizations, venipuncture, and allergy shots only. Also if you have not met your deductible for the year, payment is required when services are rendered.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### REFERRAL POLICY

I agree to abide by my insurance policy's rules regarding referrals to specialists and ancillary services (i.e. using specialists and ancillary services within my insurance plan and network). I understand that Our Kids MD LLC has a policy, which includes requesting referrals at least 1 week prior to your specialist visit. No post-dated referrals will be issued.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### GUARANTOR LIABILITY RESPONSIBILITY

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have completed all of the above questions and I certify that the information is true and correct to the best of my knowledge. I will notify the office of any changes in the above information, insurance status or health status. I authorize payment of medical benefits to Our Kids MD LLC for services rendered to me. I also understand and agree that in case of default I will be responsible for all attorney fees and collection fees incurred on this account.

I also understand I am liable for knowing and understanding my insurance coverage. This includes that you must be the designated Primary Care Physician and/or primary site at the time services are rendered, or I will become responsible for any payment due. I am also responsible for knowing my insurance policies with regards to well and sick visits as well as immunization coverage. Please inform the office staff if your insurance policy does not cover vaccines, or if you have no insurance coverage. (Your child may be eligible for State of Maryland Health Department vaccine coverage). I am also advised that many insurance carriers will only pay for services that it determines to be reasonable and necessary. Our Kids MD, LLC believes that your physician is in the best position to know the clinical assessment needs of his or her patients. In some cases, when a physician orders a specific test to either detect presymptomatic diseases as part of a process to help determine what the diagnosis is some insurers will not pay for the test performed in this case, you would be responsible for any charges incurred. (You may always check your coverage by calling your insurance carrier).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_