CROSSROADS PEDIATRICS

2025 Annual Update/Coordination of Benefits

A. PATIENT INFORMATION

Last Name:_____ First Name:_____ Date of Birth:_____ Gender: □Male □Female

Siblings:_____

Email address: (REQUIRED)_____ Home Address:_____APT_____

City_____ Zip Code:_____ Pharmacy:_____

Mother: Last Name_____ First Name_____ DOB:_____

Cell:_____ Work:_____ Occupation_____

Step-Mother: Last Name_____ First Name_____ DOB:_____

Cell:_____ Work:_____ Occupation_____

Father: Last Name_____ First Name_____ DOB:_____

Cell:_____ Work:_____ Occupation_____

Step-Father: Last Name_____ First Name_____ DOB:_____

Cell:_____ Work:_____Occupation_____

B. PRIMARY INSURANCE INFORMATION

Primary Insurance Company:_____ Start Date of Coverage_____

Insurance Subscriber or ID#:_____ Group #:_____ Name of Employer_____

Main Insured Person:_____ DOB:_____ Social Security Number_____

Main insured's relationship to patient: □Natural Parent □Step Parent □Grandparent □Legal Guardian □Other:_____

C. COORDINATION OF BENEFITS

Does the patient have other insurance? □Yes, complete secondary insurance info below □No, skip to section D

Secondary Insurance Company:_____ Insurance Subscriber or ID#:_____

Group #:_____ Main Insured Person:_____ DOB:_____

Name of Employer_____ Start Date of Coverage_____

Main insured's relationship to patient: □Natural Parent □Step Parent □Grandparent □Legal Guardian □Other:_____

Child resides with: □Natural Parent □Step Parent □Grandparent □Legal Guardian □Other:_____
Is there a court decree that has assigned primary responsibility for health coverage? □Yes □No, I certify that the above information is true and correct.

D. Signature_____ Print Name_____ Date_____

Patient Communication:

Would you like to receive email reminders, text messages and telephone calls with appointment reminders and important messages, such as lab results, etc. referral info: □ Yes □ No

*We request information on Ethnicity/Race to meet Federal Meaningful Use criteria: Ethnic Group: ___Hispanic ___Non-Hispanic

Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian/Pacific Islander

□ White Patient's Primary Language: □English □Spanish □Other:_____

Birth Hospital_____ OB/Gyn Dr:_____

Names of any specialists that your child has seen:

_____

_____

NEWBORNS: Please make sure that you add your new baby to your insurance policy within 30 days of birth to ensure coverage and select Edward Madrid, MD as your baby's primary care provider if a PCP is required.

CONSENT FOR TREATMENT/PAYMENT/ASSIGNMENT OF BENEFITS/HIPAA

• I understand that I am financially responsible for all professional charges that my child may incur.

• INSURANCE: I authorize the release of any medical or other information necessary to process this claim. I hereby authorize payment of medical services to Crossroads Pediatrics. I understand that I am financially responsible for all co-payments, deductible or coinsurance at the time of service. Please note that Billing statements are sent electronically by email only.

• SELF-PAY: I understand that charges for services rendered are due at the time of service. _____ (Please initial)

• I have the legal right to consent to medical and surgical treatment because (a) I am the patient or (b) I am the parent/guardian of the patient with medical decision-making authority _____ (Please initial)

• I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers at Crossroads Pediatrics and their designated associates or assistants believe are necessary. I also consent to the taking of photographs or films related to the care and treatment of the patient and understand that such photographs or films may be made part of the medical record. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers in this medical office to provide treatment as long as a physician/patient relationship exists, or until I withdraw my consent. _____ (Please initial)

• Sharing Records for Treatment: We share medical records with other health care providers such as specialists to allow and promote continuity of care among providers._____ (Please initial)

I agree to the above statements and attached in the "Office Policies"
paperwork. I have received or have been given the opportunity to receive a copy of HIPAA Notice of Privacy Practices for Crossroads Pediatrics.

Signature_____ Print Name_____

Date_____ Relationship to Patient_____