CONTACT & ACKNOWLEDGMENT OF RECEIPT OF POLICIES

BROOMFIELD PEDIATRICS
an affiliate of Community Reach Center

Full Legal Names of ALL Children who will be patients (oldest to youngest)

First	Middle	Last	M/F	Date of Birth

Method of Contact
I give permission to Broomfield Pediatrics to leave a phone message with information regarding my child's medical care at the number(s) listed below.

Primary phone number _____

Secondary phone number _____

Acknowledgment of Receipt of Notice of Privacy Rights
I have received a copy of Broomfield Pediatrics privacy rights. _____ **initial**

Returned Checks
When you provide us a check as payment you authorize us to use the information from the check to make a one-time electronic fund transfer from your account, or to process the payment as a check transaction. Returned checks are assigned to PFC Check Solutions and electronically re-presented through ETP (Electronic Transaction Partners) for the face amount plus a $20.00 Service Charge an all applicable costs of collection pursuant to C.R.S. 13-21-109.

Acknowledgment of Receipt of Broomfield Pediatrics Financial and Office Policies Document
I have received a copy of Broomfield Pediatrics Financial and Office Policies. _____ **initial**

As of _____ (date) my signature will be accessible in an electronic format and serve as a legal copy of authorization for services including our Financial and Office Policy.

_____ _____
Signature of Parent/Guardian /Patient **Date**