CONTACT & ACKNOWLEDGMENT OF RECEIPT OF POLICIES



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	
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Secondary phone number	
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Acknowledgment of Receipt of Notice of Privacy Rights

I have received a copy of Broomfield Pediatrics privacy rights.

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.

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

initial

initial

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