

**The Samra Group, LLC
Pediatrics & Adolescent Medicine**



200 Perrine Road Suite 229
Old Bridge, NJ 08857
(732) 727-8800

733 North Beers Street Suite L5
Holmdel, NJ 07733
(732) 739-2100

Patient's name _____ **Age** _____ **Date of Birth** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Telephone # _____ **SS #** _____ **Sex M** ___ **F** ___

Significant Medical Info _____

Medication currently taking _____ **Allergies** _____

PHARMACY NAME & ZIP CODE _____

Father's name _____ Age _____ Date of Birth _____ SS # _____

Fathers employer _____ Work /cell # _____

Mother's name _____ Age _____ Date of Birth _____ SS # _____

Mothers employer _____ Work/cell # _____

Siblings (please list last name)

Medical Insurance _____ **I.D. #** _____

Group # _____ **Subscriber** _____

Secondary Insurance _____ **I.D. #** _____

Group # _____ **Subscriber** _____

I authorize the release of any medical information necessary to process my claim. I hereby authorize payment directly to **The Samra Group** the insurance benefit otherwise payable to me. I understand I'm financially responsible to the doctor for charges not covered by this assignment.

Authorization for Disclosure of information:

I hereby authorize The Samra Group to disclose complete information concerning his/her medical findings and treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment, to those individuals who, in Dr. Barakat/Dr. Quiba's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Signature of Patient/Subscriber _____ Date _____

Make all checks Payable to The Samra Group

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**Patient Consent for the use and disclosure of
Protected Health Information**

With my consent, The Samra Group may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to The Samra Group's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Samra Group reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

The Samra Group Privacy Officer
733 North Beers Street Suite L5
Holmdel, N.J. 07733

With my consent, The Samra Group may mail to my home or other designated location and leave a voicemail message or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, The Samra Group may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as a appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request The Samra Group to restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to The Samra Group's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, The Samra Group may decline to provide treatment.

Signature of Parent/ Legal Guardian: _____

Patient Name: _____ Date: _____

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**Patient Protected Health Information
Disclosure Authorization**

Please provide us with a list of relatives and/or friends in which you would like us to be able to release information to.

1.) Name: _____ Relationship: _____

2.) Name: _____ Relationship: _____

3.) Name: _____ Relationship: _____

4.) Name: _____ Relationship: _____

5.) Name: _____ Relationship: _____

Listed above are the name of relatives and/or friends in which the physicians and staff of The Samra Group have my permission to disclose and discuss my child's protected health information that is related to my past, present, and/or future physical or mental health condition and related healthcare services. I understand that this authorization will remain in effect until a written request is submitted stating otherwise.

Patient Name: _____ Date of Birth: _____

Parent/ Legal Guardian's Signature: _____

Date: _____

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Patient's Name: _____

Date of Birth: _____

Today's Date: _____

I, _____(Parent/Guardian), give permission for The Samra Group to administer all appropriate immunizations to my child.

Signature: _____

I am aware that my insurance company may/ may not cover the following injections:

- Pediarix (DTaP, IPV, HepB)
- Menactra
- Tdap
- Varivax
- Hepatitis A
- Gardasil (HPV)

I understand that I am responsible for any charges my insurance company does not cover.

Parent/ Guardian Signature: _____ Date: _____

Witness Signature (Office Staff): _____

**THE SAMRA GROUP, LLC
PEDIATRICS & ADOLESCENT MEDICINE**



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Please let us know how you were referred to our office.

Patient referral: If so, please tell us their name so we may thank them.

Advertising: If so, please tell us where.

Other:

Thank you.