REIS PEDIATRICS

KAILUA PROFESSIONAL CENTER I | 30 AULIKE ST, SUITE 500, KAILUA, HI 96734 | 808.263.8822 WWW.REISPEDIATRICS.COM

PATIENT-PROVIDER AGREEMENT (18 YEARS AND OLDER)

Name: Date of birth

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I have read and understand the following documents that were given to me to review. I understand that these documents can be found on Reis Pediatrics website.

1. Patient-Provider Agreement
2. HIPPA Patient Acknowledgement
3. Patient Financial Responsibility
4. Medicare Lifetime Authorization
5. Insurance Authorization
6. Medical Treatment Authorization

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Signature **Date**

As required by the Affordable Care Act, we have been asked to collect the following information for the federal government:.

Please circle one answer from each question:

1. Ethnicity: Hispanic/Latino Non Hispanic/Latino Refuse to Report

2. Race: American Indian or Native Alaskan Asian Black or African American
   White Native Hawaiian or Other Pacific Islander
   More than one race Refuse to Report

3. Preferred Language: English If other please specify___________________