WEST HILLS PEDIATRICS
Patient Info---Please PRINT Clearly

Today's Date : _____

Patient:_____ DOB:_____

Patient Address_____ City_____Zip_____

Contact Info:

☐ Home Phone_____ ☐ Mom Cell_____ ☐ OK to text
☐ Patient Cell_____ ☐ Dad Cell_____ ☐ Ok to email
(Please check the preferred # of contact) Preferred Email:_____

Pharmacy Name/Location:_____

How Did You Hear About Us?_____

Full Name(s) of Parents/Step-Parents or Legal Guardian

1._____ DOB_____ Relationship_____
2._____ DOB_____ Relationship_____
3._____ DOB_____ Relationship_____
4._____ DOB_____ Relationship_____

List ALL Siblings

1._____DOB_____
2._____DOB_____
3._____DOB_____
4._____DOB_____

Emergency Contact Name/Phone Number/Relationship_____

Demographic Info

Preferred Language: _____ **Gender:** ☐ **M** ☐ **F**

Ethnicity:

☐ **Hispanic**
☐ **Not Hispanic or Latino**
☐ **Unknown**
☐ **Decline to Specify**

Race:

☐ **Asian**
☐ **Other: Pacific Islander**
☐ **American Indian**
☐ **More than one race**
☐ **Other/not listed**
☐ **Native Hawaiian**
☐ **Black/African American**
☐ **White**
☐ **Unreported/refused**
☐ **Unknown**

Name of person filling out form_____

WEST HILLS PEDIATRICS
THERESA CROCENELLI

974 Beaver Grade Rd
Moon Twp., PA 15108
412-264-6117

Consent for Treatment in the Absence of a parent/Legal Guardian

I hereby give permission and written consent to West Hills Pediatrics, its Physicians, employees and agents to render any and all medical treatment as deemed necessary to my minor child in my absence. I understand that this may include invasive procedures including, but not limited to injections:

Patients Name: _____ DOB_____

Select One:

☐ This permission applies to whomever accompanies my child to the office.

☐ This permission applies to only the people who are listed below:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

Parent/Legal Guardian

Signature: _____ Date:_____

Witness:_____ Date:_____

If the patient is a minor under 18 years of age, his/her consent is acceptable for the following reason(s):

☐ Married ☐ High School Graduate ☐ Pregnancy/birth of child

WEST HILLS PEDIATRICS

H.I.P.A.A Signature Page

A copy of the Privacy Practices used by this office will be issues upon request. Theresa Crocenelli, M.D. reserves the right to modify the privacy practices outlined in the notice.

X_____ X_____

Printed Name of Patient Patients Signature

_____ _____ _____

Date Patient Representative Relationship to Patient

Standard Authorization of Use & Disclosure of Protected Health Information

Unless noted below, your healthcare information can be shared with all entities outlined in the notice of Privacy Practices.
The Following are persons/organizations to which my information MAY be shared with : (i.e. Parent/ Grandparent/ Guardian/Spouse, etc.)

_____ Relationship: _____

_____ Relationship: _____

The following are persons/organizations with whom my information MAY NOT be shared with:

_____ Relationship: _____

_____ Relationship: _____

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to West Hills Pediatrics ATTN: AMY PIATT, Office Manager.
Potential for Re-Disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protections of the privacy of this information once West Hills Pediatrics disclosed it to another party.

WEST HILLS PEDIATRICS

FINANCIAL POLICIES FORM

Please take the time to read, sign, and date this Financial Policies Form. If you feel you need any additional information or explanation, please call our billing office at 412-264-6117 and our billing specialist will be glad to answer any questions.

All patients will be asked to complete our registration process and provider proof of identity. In addition, all patients must provide us with a copy of the current insurance card at each visit.

We submit our services to your insurance company as a courtesy to you. However, you are responsible for the balance of the account and any portion not paid by your insurance. Under these plans the patient or responsible party may be required to pay a deductible, co-pay, or co-insurance for covered and non-covered good and services.

It is your responsibility to know your insurance plan benefits. Routine physicals, immunizations, certain lab tests, procedures and prescribed medication may not be covered. We encourage you to contact your insurance carrier ahead of time and verify appropriate coverage. Payment is expected in full when services are rendered, unless other arrangements have been made with West Hills billing office. Those without any medical insurance may be offered a discounted rate.

There are times when making a payment can be a financial hardship. Please contact our billing office to discuss special payment arrangements if necessary.

We reserve the right to charge for missed appointments if 24 hours' notice is not given. West Hills Pediatrics also reserves the right to discharge a patient from our practice after 4 or more "NO SHOWS" or last-minute cancellations occur in one 12-month period.

There will be a $30.00 insufficient funds fee added to your account in the event of a returned check.

There is no charge to copy and send your Medical Records to another physician for continuation of care. We will charge a fee to copy and send your medical records to a third party for other purposes including, but not limited to, disability claims and legal actions. We will assess a fee for hand carried Medical Records.

I have read the above and understand the financial policies of West Hills Pediatrics.

_____ / _____ / _____

Parent/ Patient signature Date Patient Name

WEST HILLS PEDIATRICS

412-264-6117
974 BEAVER GRADE RD. MOON TOWNSHIP, PA 15108
1781 PINE HOLLOW RD. MCKEES ROCKS, PA 15136

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Acknowledge of Receipt of Notice of Privacy Practices:

I acknowledge that I have received and read the above Notice of Privacy Practices and that I have had any questions regarding the notice answered to my satisfaction.

_____/_____
Patient Name (print) DOB

_____/_____
Patient Representative (print name) Relationship

_____/_____
Signature of Patient Rep or Patient if over 18 Date

West Hills Pediatrics
Patient No-Show/ Cancellation Policy

In order for West Hills Pediatrics to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner.

Effective November 5, 2012, if you miss your appointment or cancel with less than 24 hours notice, WHP reserves the right to bill you $25.00 for each no-show and late cancellation. This fee will be your responsibility and will not be billed to your insurance company.

We do realize that on a rare occasion emergencies may arise and we will address these situations with you at that time.

In addition to the $25 fee with each missed appointment- we will notify you of you have missed one (1) or two (2) appointments to remind you of our policy. Additionally, we reserve the right to terminate our relationship with you after three (3) or more occurrences. Good medical care and a positive doctor-patient relationship are dependent upon consistent consultation and treatment. This cannot be accomplished with frequently missed appointments.

By signing below, you are acknowledging that you have read and understand our policy and agree to the terms and conditions as set forth above. We thank you for working with us to ensure services are provided to you in the best possible way.

Patient Name:_____ (please print)

Patient Signature of over 18 years:_____ Date_____

Parent Signature if child is a minor:_____ Date_____