NEW PATIENT FORM (PEDIATRIC)

Date: ____________________

PATIENT INFORMATION

Patient LAST NAME ______ FIRST NAME ______ MIDDLE NAME ______ PREFERRED NAME ______

Address STREET or P.O. BOX ______ CITY ______ STATE ______ ZIP ______

HOME PHONE ______ CELL PHONE ______ GENDER (M/F) ______ DATE OF BIRTH ______ AGE ______ SOCIAL SECURITY # ______

In an effort to eliminate disparities in health care in the United States, the U.S. Dept. of Health and Human Services requested us to collect the following demographic data so that those disparities can be better identified.	Primary language spoken by patient ______	Ethnicity: ____Hispanic or Latino ____Not Hispanic or Latino ____Declined	Race: ____ White ____ Asian ____ Black/African American ____ American Indian/Alaskan Native ____ Native Hawaiian/Pacific Islander ____ Other ____ Declined

FATHER'S INFORMATION

NAME ______

STREET ______ CITY ______ STATE ______ ZIP ______

HOME PHONE ______ WORK PHONE ______ CELL PHONE ______

EMPLOYER ______

OCCUPATION ______ SOCIAL SECURITY # ______

STEP-PARENT (if applicable) ______

FATHER is ____ MARRIED ____ SINGLE ____ DIVORCED ____ WIDOWED

MOTHER'S INFORMATION

NAME ______

STREET ______ CITY ______ STATE ______ ZIP ______

HOME PHONE ______ WORK PHONE ______ CELL PHONE ______

EMPLOYER ______

OCCUPATION ______ SOCIAL SECURITY # ______

STEP-PARENT (if applicable) ______

MOTHER is ____ MARRIED ____ SINGLE ____ DIVORCED ____ WIDOWED

CHILD PRIMARILY LIVES WITH: *(please specify)* ______ *Relationship to Patient* ______

DATE OF BIRTH ______ SOCIAL SECURITY # ______ ☐ MALE ☐ FEMALE GENDER

ADDRESS ______ CITY ______ STATE ______ ZIP ______

( ) HOME PHONE ______ ( ) WORK PHONE ______ ( ) CELL PHONE ______

OTHER FAMILY MEMBERS WHO LIVE IN THE SAME HOUSEHOLD AS PATIENT

NAME	Date of Birth	GENDER	RELATIONSHIP	SEEN HERE?
		☐ MALE ☐ FEMALE		☐ YES ☐ NO
		☐ MALE ☐ FEMALE		☐ YES ☐ NO
		☐ MALE ☐ FEMALE		☐ YES ☐ NO
		☐ MALE ☐ FEMALE		☐ YES ☐ NO
		☐ MALE ☐ FEMALE		☐ YES ☐ NO
		☐ MALE ☐ FEMALE		☐ YES ☐ NO
		☐ MALE ☐ FEMALE		☐ YES ☐ NO

EMERGENCY CONTACT:

	Relationship	PRIMARY PHONE-Home/Mobile/Work	SECONDARY PHONE Home/Mobile/Work
PRIMARY PERSON TO CONTACT - NAME			
PERSON TO CONTACT # 2 - NAME			

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
AND
AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION

Thank you for selecting our office for your children's medical care. We strongly feel that all patients deserve the very best medical care that we can provide. Furthermore, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our financial policy.

1. I authorize this office to release or receive any information necessary to expedite the processing of any and all insurance claims.
2. I hereby authorize this office to bill my insurance company directly for their services.
3. I authorize payment directly to this physician of any insurance benefits otherwise payable to me.
4. In the event that I receive payment from my insurance carrier, I agree to endorse many payment I receive over to my physician for which these fees are payable.

I understand that I am directly and fully financially responsible to this physician for any charges deemed as non-covered by my insurance company. Such charges could be labs, vision tests, hearing tests, or child checkups and/or immunizations. I also understand that I am responsible for paying any co-pays, percentages, and/or deductibles at time of service not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment, or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment within 90 days, it is my full responsibility to pay my doctor's bill directly. I further understand and agree that if I fail to make timely payments on my account I will be responsible for any and all reasonable costs of collection proceedings, including court costs, filing fees, and attorney's fees.

NOTE:
The AllKids Program will not pay for a pediatrician to perform vision ($31.00) and/or hearing ($34.00) tests as part of a routine check-up. However, each are deemed non-covered and billable to the patient.
Most Blue Cross plans will not pay for a TB Test ($18.00). However, it is deemed non-covered and billable to the patient.
Most insurance companies will not pay for the pediatrician to do a second PKU study. However, it is deemed non-covered and billable to the patient.

Some insurance companies will not pay for the routine check-up and/or immunizations, as well as labs. It is the responsibility of the parent and/or guardian to know the specifics of their insurance contract and be willing to pay to the provider at time of service any monies due for those services which are non-covered.

CONTRACT AND NON-CONTRACT INSURANCE COVERAGE
If we are contracted with your insurance company, you will be expected to pay your co-pay, percentage, deductible, and/or balance for any non-covered services *at the time services are rendered*. If you have insurance with a company that we are not contracted with, your charges are your responsibility and are due payable in full at the time services are rendered. We will, however, file an insurance claim as a courtesy to you.

ACCEPTED METHODS OF PAYMENT
At this time, we will accept payment of balances due by check, cash, credit card and money order.

There will be a $30.00 charge on all returned checks.

AUTHORIZATION TO RELEASE AND/OR RECEIVE INFORMATION
The patient/responsible party authorize(s) the release or receipt of and disclosure of any and all medical information related to the patient's treatment and care, to or from any entity, which is, or may be liable, for physicians' charges, or to or from any Professional Review Organization associated therewith. The patient/responsible party authorize(s) the release or receipt and disclosure of all or any part of the patient's medical records to or from any other health acre provider who may be of assistance, in the opinion of the office, in providing medical care and treatment for the patient, and/or assisting in any reimbursement or benefits to which patient may be entitled.

A photostatic copy of these authorizations and agreement shall be as valid as the original.

Signature: ______________________ Date: ______________________

Witness: ______________________

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