Primary Care Pediatrics

Please give our receptionist your *insurance card* to copy. We must have a copy of <u>all</u> cards in order to properly file your insurance. We will also need some form of *photo identification* for the adult bringing the child in for the appointment. Due to insurance requirements, we collect the patient's portion at the time of service.

DATE: _____ **PLEASE DO NOT USE PO BOXES AS YOUR ADDRESS**

#1 Parent/Guardian_____
Address _____
City _____State _____ Zip _____
Home Phone _____Cell Phone _____
Employer _____
Occupation _____
Work address _____
City, State, Zip _____
Work Phone _____
SS # _____ DOB _____
E-mail Address_____

#2 Parent/Guardian_____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Employer _____
Occupation _____
Work Address _____
City, State, Zip _____
Work Phone _____
SS #_____ DOB _____
E-Mail address _____

Provider Preference (√ one): □ Dr. Janice Algea □ Dr. Dave Algea □ Stephen Wilson, PNP □ Elaina Hogan, PNP

Patient's Race: □ AMERICAN INDIAN □ ALASKA NATIVE □ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER □ WHITE □ ASIAN □ BLACK/AFRICAN AMERICAN □ OTHER_____ □ DECLINES TO ANSWER

Patient's Primary Language: □ ENGLISH □ SPANISH □ CHINESE □ FRENCH □ OTHER_____

Patient's Ethnicity: □ HISPANIC/LATINO □ NON-HISPANIC/LATINO □ UNKNOWN □ DECLINES TO ANSWER

Patient's Religion: □ CHRISTIANITY □ ISLAM □ HINDUISM □ CATHOLICISM □ JUDAISM □ OTHER_____

Name of person responsible for Patient Account _____

Person with whom the "Children" live with _____ Relationship to Patient _____

Full Name of Children of BOTH PARENTS listed above	Sex	DOB	SS #

Emergency Contact. (Someone who **<u>does not</u>** live in your household) Home Phone _____ Cell _____

Name _____ Address _____ Relationship _____

INSURANCE INFORMATION

Primary Insurance Name _____ Name of Hospital you can use _____
Copay _____
Policy Holder's Name _____
Policy / ID Number _____ Group Name/ID _____
Secondary Insurance Name _____ Copay _____
Policy Holder's Name _____
Policy / ID Number _____ Group Name/ID _____

****Please sign the back of this form****

Primary Care Pediatrics Signature Page

INSURANCE AUTHORIZATION & BENEFIT ASSIGNMENT

I hereby authorize Primary Care Pediatrics to release all information necessary (including medical records) to insurance carriers to secure payment for my dependents or myself. I hereby assign all medical and/or surgical benefits to which I am entitled. I authorize my insurance company to reimburse Primary Care Pediatrics for any/all services rendered to myself or to my dependents. Initials: ____

STATEMENT OF FINANCIAL RESPONSIBILITY

All services rendered are the payment responsibility of the patient. As a courtesy, we will bill your insurance carrier. The parent/guardian is responsible for all fees, regardless of insurance coverage or the usual and customary fees provided by your insurance company. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am expected to pay for deductibles/coinsurance and co-pays when my child(ren) is/(are) seen in the office. I understand that I will be responsible for any costs incurred as a result of my account being turned over to a collection agency or attorney with a 30% collection fee added to any account that is turned over. Initials: ____

MEDICARE - MEDICAID CERTIFICATION

I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits be made to Primary Care Pediatrics on any bills for services furnished to me or my dependents. Initials: ____

MOTOR VEHICLE ACCIDENT POLICY

In the event services are rendered as the result of a motor vehicle accident, the responsible party agrees to be responsible for payment at the time of service regardless of insurance coverage or any settlement reached. Initials: ____

PERMISSION TO TREAT

I am giving my written permission for my child(ren) to be treated at Primary Care Pediatrics. Initials: ____

I am giving permission to Primary Care Pediatrics for prescription history retrieval. Initials: ____

Parent/Guardian PRINTED Name: _____ Relationship to Patient: _____

SIGNED: _____ Date: _____

ADVANCED DIRECTIVE (LIVING WILL)

Our office has advanced directive forms. Please check with the front desk. Do you have an advanced directive (living will) for the children listed above? Yes _____ No _____

PRACTICE GUIDELINES & PCMH WELCOME BROCHURE

I have received the Practice Guidelines & Patient Centered Medical Home brochure for this facility. Initials: _____