Primary Care Pediatrics

Please give our receptionist your *insurance card(s)* to copy. We must have a copy of <u>all</u> cards to file your insurance properly. We 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 _____
DOB _____ SS# _____
E-mail Address _____

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

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

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

<u>Patient's Primary Language</u>: □ ENGLISH □ SPANISH □ CHINESE □ FRENCH □ OTHER _____

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

<u>Patient's Religion</u>: □ CHRISTIANITY □ ISLAM □ HINDUISM □ CATHOLICISM □ JUDAISM □ OTHER _____ □ DECLINES TO ANSWER

Name of person responsible for patient account _____
Name of person with whom the children live _____ Relationship to patient _____
<u>Emergency Contact Information</u> (*someone who **does not** live in your household*)
Name _____ Relationship to patient _____ Cell phone _____
Home phone _____ Address _____

PATIENTS OF THE PRACTICE (*please include the patient booked for the appointment*)

Full Name of <u>Children</u> of <u>BOTH PARENTS</u> listed above	DOB	Sex	Gender	Social Security #

INSURANCE INFORMATION

Primary Insurance Name _____ Policy Holder's Name _____
Policy / ID Number _____ Group Name/ ID _____ Copay _____
In-Network hospital you can use _____

Secondary Insurance Name _____ Policy Holder's Name _____
Policy / ID Number _____ Group Name/ ID _____ Copay _____

****Please sign the <u>back</u> of this form****

Primary Care Pediatrics Signature Page

NO-SHOW AND LATE CANCELLATION POLICY

Please read carefully. We require 24 hours advance notice for appointment cancellation. If no notice is given and an appointment is missed, the appointment will be noted as a "no-show." If insufficient notice is given, then the appointment may be noted as a late cancellation. Although we attempt appointment reminders, ultimately, appointments booked are the responsibility of the responsible party. Please update phone numbers with the practice to ensure we can reach you. Excessive no-shows, such as 3 in a year per family, or a history of excessive late cancellations and no-shows may warrant dismissal, per the practice guidelines. Missed appointments may also result in scheduling limitations if multiple children in the family. Additionally, if your insurance carrier allows, then the **late cancellation or no-showed appointment may result in a fee of $50** billed to the responsible party. We will allow for a **5-minute grace period**, but any late arrivals after that may have to be rescheduled if the clinic cannot accommodate them. **Initials:** ___

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 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 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 normal 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 due to my account being turned over to a collection agency or attorney, with a 30% collection fee added to any account 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, 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 that medical insurance benefits be paid 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: _____

SIGNATURE: _____ Date: _____

ADVANCED DIRECTIVE (LIVING WILL)

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

PRACTICE GUIDELINES & PCMH WELCOME BROCHURE

I have received this facility's Practice Guidelines & Patient-Centered Medical Home information. **Initials:** ___