DATE: _____

Primary Care Pediatrics

Please provide your insurance card(s) to our receptionist for copying. We need a copy of all insurance cards to process your claims correctly. Additionally, we require a form of photo identification from the adult accompanying the child to the appointment. In accordance with insurance requirements, we will collect the patient's portion / copays at the time

PLEASE DO NOT USE PO BOXES AS YOUR ADDRESS

#1 Parent/Guardian _____

Relationship to Patient(s) _____

DOB _____ SS# _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Employer _____

Occupation _____ Work Phone _____

Work Address _____

City _____ State _____ Zip _____

E-mail _____

#2 Parent/Guardian _____

Relationship to Patient(s) _____

DOB _____ SS# _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Employer _____

Occupation _____ Work Phone _____

Work Address _____

City _____ State _____ Zip _____

E-mail _____

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

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

Full Name of Children of BOTH PARENTS listed above	DOB	Sex	Social Security #

Patient Race: □ AMERICAN INDIAN □ ALASKA NATIVE □ ASIAN □ NATIVE HAWAIIAN/ PACIFIC ISLANDER □ WHITE □ BLACK/AFRICAN AMERICAN □ OTHER_____ □ MIDDLE EASTERN OR NORTH AFRICAN □ DECLINES TO ANSWER

Primary Language: □ ENGLISH □ SPANISH □ CHINESE □ OTHER _____

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

Patient Religion: □ CHRISTIAN □ ISLAM □ HINDU □ CATHOLICISM □ JUDAISM □ OTHER _____ □ DECLINES TO ANSWER

Name of person **responsible for patient account** _____ Relationship to patient _____

Name of person **with whom the child(ren) live** _____ Relationship to patient _____

Emergency Contact Information (*someone who **does not** live in your household*):

Name _____ Phone _____ Relationship to patient _____

Address _____

INSURANCE INFORMATION

Primary Insurance Name _____

Policy/ ID Number _____

Group Name/ ID _____ Copay _____

1° Ins. policy holder's name _____

Policy holder's DOB _____ SS# _____

In-network hospital you can use _____

Secondary Insurance Name _____

Policy/ ID Number _____

Group Name/ ID _____ Copay _____

2° Ins. policy holder's name _____

Policy holder's DOB _____ SS# _____

****Please read carefully and sign the back of this form****

Primary Care Pediatrics Signature Page

MISSED VISITS AND LATE CANCELLATION POLICY

Please read the following carefully. We require at least 24 hours' notice to cancel an appointment. If no notice is provided and the appointment is missed, it will be recorded as a "no-show." If notice is provided too late, the appointment may be marked as a late cancellation. Although we make efforts to send appointment reminders, it is ultimately the responsibility of the responsible party to manage their appointments. Please ensure your contact information is up to date with our practice so we can reach you.

Excessive no-shows—defined as three or more per year per family—or a pattern of late cancellations and missed visits may lead to dismissal from the practice, as per our guidelines. Missed appointments may also result in scheduling restrictions, especially for families with multiple children. If your insurance permits, **a fee of $50 may be billed to the responsible party for late cancellations or missed visits. We offer a 5-minute grace period for late arrivals; however, arrivals beyond this time may need to be rescheduled if the clinic is unable to 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 Name [PRINTED]: _____ Relationship to Patient: _____

SIGNATURE: _____ Today's 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 & HIPPA

FOR NEW PATIENTS ONLY: I have received this facility's Practice Guidelines & HIPPA policy. **Initials: __**

Primary Care Pediatrics

Social Needs Questionnaire

Date: _____

Patient's name: _____ Date of birth: _____

Other children seen by practice:

_____ Date of birth: _____
_____ Date of birth: _____
_____ Date of birth: _____
_____ Date of birth: _____
_____ Date of birth: _____
_____ Date of birth: _____

Parent or Caregiver's name: _____ Phone number: _____
Best time to call: _____

For our clinic to provide the best care for your family, please answer the following questions. Your responses will be kept confidential.

		Yes / No
	In the last 12 months*, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Y N
	In the last 12 months, has the **electric, gas, oil, or water company threatened to shut off your services** in your home?	Y N
	Are you worried that in the next 2 months, you **may not have stable housing?**	Y N
	Do problems getting **child care make it difficult for you to work or study?** *(leave blank if you do not have children)*	Y N
	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	Y N
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	Y N
	Do you ever need help **reading hospital materials?**	Y N
	Do you often feel that **you lack companionship?**	Y N
	**Are any of your needs urgent?** For example: I don't have food tonight, I don't have a place to sleep tonight	Y N
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Y N

Form is attributed to Health Leads