PEDIATRIC ASSOCIATES, PC

PATIENT INFORMATION

Child's Last Name:_____ First Name:_____ MI: ____ DOB:_____SEX: _____
Address: _____
City: _____State:_____ Zip:_____

PARENT/LEGAL GUARDIAN INFORMATION

LAST, FIRST NAME: _____
PLEASE CHECK: ☐ Mom ☐ Dad ☐ Legal Guardian
SS#: _____ DOB:_____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____Cell: _____
Employer: _____
Work Phone:_____ Ext:_____
Email Address: _____
How do you wish to receive communication/reminders etc.
(you may select one): Phone / Email / Mail / Text

LAST, FIRST NAME: _____
PLEASE CHECK: ☐ Mom ☐ Dad ☐ Legal Guardian
SS#: _____ DOB:_____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____Cell: _____
Employer: _____
Work Phone:_____ Ext:_____
Email Address: _____
How do you wish to receive communication/reminders etc.
(you may select one): Phone / Email / Mail / Text

Pharmacy Name: _____ Pharmacy Address: _____
Pharmacy Number: (____)_____ Pharmacy Cross Streets: _____

INSURANCE INFORMATION

Please have your insurance cards ready for photocopying

Primary Ins.:_____ Name of Insured: _____DOB: _____
Policy #:_____Group #: _____

Secondary Ins.: _____ Name of Insured: _____DOB: _____
Policy #:_____Group #: _____

INSURANCE RELEASE INFORMATION

I hereby authorize the office of Pediatric Associates, P.C. to release to my insurance company any necessary information needed to file and expedite payment on my claim. I further assign any benefits payable on my behalf to Pediatric Associates, P.C. I understand I am financially responsible for any balance not covered by my insurance carrier.

_____ _____
Parent/Guardian Signature Date

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BIRTH HISTORY

Place of Birth: _____ Time: _____am/pm Referred by: _____

Problems During Pregnancy: _____

Problems During Delivery: _____

☐ Vaginal or ☐ Cesarean (check one)

Birth Weight:_____ Birth Length:_____

FEEDING

☐ Breast or ☐ Formula (check one) Formula Type:_____

Supplements: ☐ Vitamins ☐ Iron ☐ Fluoride (check one)

Diet Evaluation: ☐ Good ☐ Fair ☐ Poor (check one)

SOCIAL HISTORY

Mother is: ☐ Single ☐ Married ☐ Divorced ☐ Remarried ☐ Separated ☐ Widowed (check one)

Names of adults in home: _____

Occupations Mother: _____ Father: _____

Child lives with: ☐ Both Parents ☐ Mother ☐ Father (check one) Other: _____

Child is cared for by: Parents Day Care Head Start School Age

DEVELOPMENT

Age Sitting:_____ Walking: _____

Note below any problems with hearing, vision, growth, development, toilet or speech.

_____

FAMILY HISTORY

Note below any family history of TB, allergy/asthma, emotional problems, convulsions, inherited disease or heart disease.

Age Mother: _____ Health Evaluation: ☐ Good ☐ Fair ☐ Poor (check one)

Age Father: _____ Health Evaluation: ☐ Good ☐ Fair ☐ Poor (check one)

Siblings: Names/Ages: _____ Health Evaluation: ☐ Good ☐ Fair ☐ Poor (check one)

(Please use other side if needed to list all siblings)

CHILD'S PAST MEDICAL HISTORY

Health Evaluation: ☐ Good ☐ Fair ☐ Poor (check one)

Previous hospitalizations or serious illness: _____

Previous operations (explain):_____

Allergies: _____

Current medications including vitamins:_____

Problems or concerns with: _____

Are immunizations up to date? ☐ Yes or ☐ No (check one) Please have a copy of all immunizations ready for the Doctor.

Comments:_____

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POS Reorder # 1303645

PEDIATRIC ASSOCIATES, PC

FINANCIAL AGREEMENT

Payment: If you have a copay, coinsurance, deductible, or are self-pay visit, please know that payment is due at the time of service. Payment is expected at the time of service by any adult bringing the patient to their appointment, including caregivers. We accept cash, check, Visa, MasterCard, Discover, and American Express. Pediatric Associates, PC will not be party to custodial, separation or financial disputes relating to individuals regarding minor children to whom services are provided. **The individual who requests the medical services and/or signs the financial agreement is responsible for any balance due.**

Returned checks will result in a $40.00 fee that will be posted to your account. We will only accept cash and credit card for payment after a returned check is received. Returned check and other office fees, balances older than 60 days, and failure to pay account balances as promised will be subject to external collection along with additional collection fees, including attorney and other court fees. Your credit record may be investigated to determine your ability to pay your debt.

Insurance: In order to help you receive your maximum insurance allowable benefits, we need your assistance and understanding of our payment policy. We do our best to obtain benefit information from insurance, but we have limited access due to the multiple plans available by each insurance carrier. Additionally, they advise us that the information they give us is not a guarantee of benefits. **You will need to know your benefits to ensure proper coverage.**

We require a copy of insurance card in order to bill your visit appropriately. If you cannot furnish an insurance card at the time of visit, you will be responsible for payment in full at the time of service. It is not the responsibility of our office to obtain this information for you. We will be happy to supply you with an itemized bill of the visit so that you may submit this information to your insurance company for reimbursement.

You will be asked to update your personal and insurance information every 6 months or as information changes because we are required by law to obtain your signed authorization to submit claims to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/ or expulsion from our insurance plan.

We will gladly submit fees for your covered medical services to your insurance company. **It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 30 days, or if they deny the claim.** It is your responsibility to understand your coverage and benefits, including if we are in network with your plan, precertification, referral and authorization requirements. We will, however, assist you ensure that all plan requirements are met. **NOTE There is an additional charge with your office visits for Saturday.**

Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. We must emphasize that as medical providers, our relationship is with you, not your insurance company.

RECEIPT of Notice of Privacy Practices

I have been offered the HIPAA Notice of Privacy Practices which outlines my privacy rights and how Pediatric Associates, PC may use and disclose Protected Health Information about me.

Yes No Offered but Decline Initials: _____

I have read the above Office Information, Financial Agreement, and HIPAA Notice. My signature below acknowledges that I understand and agree to the terms and conditions outlined herein.

_____	_____	_____
Parent/Guardian Name (Please Print)	Parent/Guarantor Signature	Date

PEDIATRIC ASSOCIATES, PC

OFFICE INFORMATION, FINANCIAL AGREEMENT, HIPAA NOTICE

Welcome to Pediatric Associates,

Pediatric Associates, PC appreciates the confidence you have shown in choosing us to provide for your child's health care needs. Please be sure to visit our website at www.pediatricassociates.com for lots of information about our services, as well as resources to help you with your children's health issues. Below are some important topics, as well as our Financial Agreement with you. Please read it carefully and sign on the next page.

Appointments: We ask that all our patients arrive 15 minutes early for their appointment. We also ask that you bring a photo ID, insurance card, and form of payment to each appointment. We will scan your photo ID and insurance card into the system to keep on file for future reference. Should you require any paperwork to be completed for your appointment, you can download the forms from our website on the "Forms" page, then fill it out at home to bring with you to your visit. Otherwise we will simply give you the paperwork when you arrive to have you complete here in our office. A courtesy appointment confirmation will be made a day prior to your appointment.

Late Arrivals: If you arrive 15 minutes or more late after your scheduled appointment time, we reserve the right to reschedule your appointment. If you know you are running late, please call our office so that we can either change your appointment time or confirm the provider would still be able to still see you if you arrive late.

Cancellations and No Shows: Please provide at least 24 hours advance notice if you wish to reschedule or cancel your appointment. Repeated missed appointments may result in dismissal from the practice. A **$35.00** no show fee may be applied to your account for **EACH** missed appointment if you fail to come in for your appointment. No show charges are not covered by insurance plans. If you have three no show appointments, you could be discharged from the practice.

Well Visit with other concerns: Please be advised that if you are scheduled for a routine well visit, but also have health issues that need to be evaluated at the same time, we may need to bill your insurance for both well visit and the evaluation of the services outside the scope of a routine physical.

Medical Records: If you should require copies of medical records, please go to our website, on the Patient Info Tab click and choose Forms download the Medical Records Release form. Once we receive the completed form, we will process your request with 3 business days. Please be aware there may be a minimum fee of $25 per child associated with the record requests. **FMLA paperwork or specialty letters will be a minimum fee of $25 depending on the time and information required to complete.**

Divorce/Separated/Custody Arrangements: We cannot and will not become involved with parental billing disputes in divorce and/ or custody cases. Our policy is to hold the parent who brings in the child for medical treatment responsible for payment at time of service. Pediatric Associates require documentation from the court for all legal matters that relate to your child's care; i.e. custody, medical decisions, medical record access, etc.