PEDIATRIC PARTNERS
VALLEY VIEW

Please Complete ALL information and sections

Patient/Child 1:_____
Last *First* *Middle* *Nickname*

Patient's PCP: _____

Date of Birth _____ **Male/ Female** **Preferred Language**_____

Ethnicity (circle): Hispanic/Non-Hispanic/Unknown **Race (circle)**: White/Asian/Black/Hawaiian/ Native American

Mother/Father/Step-Parent/Adoptive Parent/Legal Guardian/Other_____(Please Circle One)

Primary Contact: _____
Last Name First Name Middle Name

Lives with Patient? Yes / No Social Security #_____ Date of Birth _____

Mailing Address_____
Street City State Zip

Primary Phone _____Cell _____Work _____Home_____

Employer _____ Employer Address _____

Email _____Preferred Language_____

How would you ideally prefer to be contacted regarding: (Circle only one for each category)

Medical Issues	*US Mail / Home Phone / Work Phone / Cell Phone / Text / Email*
Appointment Reminders	*US Mail / Home Phone / Work Phone / Cell Phone / Text / Email*
Recall Notices	*US Mail / Home Phone / Work Phone / Cell Phone / Text / Email*
Billing Statements	*US Mail / Email / Text*
General Practice Notices	*US Mail / Home Phone / Work Phone / Cell Phone / Text / Email*
Patient Portal Notifications	*Text / Email*

Mother/Father/Step-Parent/Adoptive Parent/Legal Guardian/Other_____(Please Circle One)

Contact 2:_____
Last Name First Name Middle Name

Lives with Patient? Yes / No Social Security #_____ Date of Birth _____

Mailing Address_____
Street City State Zip

Primary Phone _____Cell _____Work _____Home_____

Employer _____ Employer Address _____

Email _____Preferred Language_____

If the contact2 needs to be notified in addition to contact1 for the below please circle as appropriate, otherwise leave blank.

Medical Issues	*US Mail / Home Phone / Work Phone / Cell Phone / Text / Email*
Appointment Reminders	*US Mail / Home Phone / Work Phone / Cell Phone / Text / Email*
Recall Notices	*US Mail / Home Phone / Work Phone / Cell Phone / Text / Email*
Billing Statements	*US Mail / Email / Text*
General Practice Notices	*US Mail / Home Phone / Work Phone / Cell Phone / Text / Email*
Patient Portal Notifications	*Text / Email*

Patient/Child 1 Name_____ **Date of Birth**_____ 

Please list ALL members of the family that are or will be PATIENTS of the practice.

Patient/Child 2 (*Last, First, Middle initial*)	Sex (*Circle*) M/F	Preferred Language
Date of Birth:		

If information is different than Patient 1, Please complete the section below

Address and Phone (*Street, City, State, Zip, Primary Phone #*) □ Resides in same home □ Does not live in same home □ Lives part time in home	Mother's Name/ DOB *(Last, First)* Father's Name/DOB *(Last, First)*	Ethnicity (Circle) Hispanic/ Non- Hispanic/ Unknown	Race (Circle) White/Asian/Black/ Hawaiian/Native American

Patient/Child 3 (*Last, First, Middle initial*)	Sex (*Circle*) M/F	Preferred Language
Date of Birth:		

If information is different than Patient 1, Please complete the section below

Address and Phone (*Street, City, State, Zip, Primary Phone #*) □ Resides in same home □ Does not live in same home □ Lives part time in home	Mother's Name/ DOB *(Last, First)* Father's Name/DOB *(Last, First)*	Ethnicity (Circle) Hispanic/ Non- Hispanic/ Unknown	Race (Circle) White/Asian/Black/ Hawaiian/Native American

Patient/Child 4 (*Last, First, Middle initial*)	Sex (*Circle*) M/F	Preferred Language
Date of Birth:		

If information is different than Patient 1, Please complete the section below

Address and Phone (*Street, City, State, Zip, Primary Phone #*) □ Resides in same home □ Does not live in same home □ Lives part time in home	Mother's Name/ DOB *(Last, First)* Father's Name/DOB *(Last, First)*	Ethnicity (Circle) Hispanic/ Non- Hispanic/ Unknown	Race (Circle) White/Asian/Black/ Hawaiian/Native American

Please list any additional persons living in the child's home and their relationship to the child:

_____

Are there any siblings not listed? If so please list their names, ages and where they live.

_____

Patient/Child 1 Name_____ **Date of Birth**_____ 

Additional Contact Questions:
Who should receive billing statements?_____
May all contacts have access to the patient's records electronically? Yes / No / _____

May we leave detailed phone messages related to patient care (to include lab results, diagnosis, answers to questions, medications, instructions or anything else that might be contained in the patient chart) on the phone numbers provided? Yes / No /

_____

If parents are divorced or separated, or the child does not live with the parents, please complete this section:
Who has custody?_____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction:
_____

Other Legal Guardian or Financially Responsible Person

_____
Last Name First Name Middle Name *Relationship/Title*

Social Security #_____ Date of Birth _____ Email _____

Address_____
Street City State Zip

Home Phone _____ Cell _____Work _____

Employer _____ Employer Address _____

Emergency Contact Name 1 _____ Relationship_____

Address_____
Street City State Zip

Phone Number (1) _____ Phone Number (2) _____

Authorization to Treat and/or Discuss Treatment or Results and or Procedures

(allows others to bring child into office and/or receive results or follow-up instructions)

I,_____ authorize the following people to consent to evaluation and treatment of above named patient, including patient if listed and patient is at least thirteen (13) years of age:

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Authorized Signature _____ **Date** _____

Patient/Child 1 Name_____ **Date of Birth**_____ 

CONDITIONS OF SERVICE

Consent to Treat

I (for named patient) voluntarily consent to such clinical care involving medical evaluation, diagnostic procedures and medical treatment as may be ordered by my physician or consulting physicians, their assistants or their designees. I understand that the services provided for the undersigned patient are under the control and direction of my physician. I also am aware that the practice of medicine and surgery is not an exact science and agree to hold practice/physician harmless. I acknowledge that no guarantees have been made concerning the result of any treatment or examinations to be rendered. I authorize this facility and its designees to dispose of and/or preserve for medical diagnostic purposes any tissue removed during any procedure.

Initial_____

Release of Information

I authorize Pediatric Partners and its designees to release such patient and guarantor information from the patient's medical or financial records as may be necessary for the processing of insurance claims; for advance, concurrent, or retrospective review of services; for receipt of benefits; or for continuity of health care. The information may be released to third party payers and their agents and/or health care providers involved in care rendered in the clinic or in continuing care. I also understand that such information may be released as permitted or required by law.

Initial_____

Acknowledgement of notice of privacy practices

I herby acknowledge that I had the opportunity to review the Pediatric Partners notice of privacy practices. I also consent to be contacted by regular mail, by email or by telephone (including a cell phone number) regarding any matter related to our account with Pediatric Partners, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages. I also agree to have appointment reminders sent to me by open post card.

Initial_____

Financial Responsibility

The undersigned agrees to assist in the processing of claims for benefits and understands that he/she is totally responsible for payment of all clinic charges for services rendered, regardless of insurance coverage or other responsible parties. The undersigned understands that they are responsible for the prompt payment of any portion not covered by insurance including coinsurance, deductibles and co-pays and may be responsible for non-covered services and claims denied by your insurance. The undersigned acknowledges that the payment of co-pays is expected at time of service as well as any prior outstanding balances.

Initial_____

Assignment of Insurance Benefits

In order for Pediatric Partners to bill your insurance plan or submit a claim on your behalf we require a valid credit card or direct bank debit account information prior to services being rendered (***Colorado Medicaid patients exempt***) . Your credit card / debit card will be kept on file. Your credit card / bank account will not be charged until 30 days after the services provided have been processed by your health insurance carrier and the balance deemed your responsibility. We will attempt to notify you by statement and or letter at the address provided of any outstanding balances prior to Pediatric Partners charging your account or card at which time you may use a different form of payment to settle your account. Regardless of being able to contact you though, by providing your card and receiving provided services, you are authorizing Pediatric Partners to charge your provided credit / debit card for any unpaid bills or claims. Without a card on file, a refundable deposit of the estimated balance is due in full at the time services are rendered. Any claims paid after your card has been billed or receipt of your deposit will be refunded. With a card on file we will file an initial claim with the insurance company, or other third party payer, if the undersigned has provided the necessary information and any required forms. The undersigned agrees to assist our office in the processing of claims for insurance or other benefits. Further he or she understands that if the insurance company or other payer does not make a payment on the claim within forty-five (45) days of submission, it is their responsibility to pay the clinic at that time or make other payment arrangements acceptable to the clinic. The undersigned agrees to keep all insurance and demographic information current and will notify the clinic in writing of any changes. Any charges incurred by a minor are the responsibility of the minor's legal guardian(s).

I authorize direct payment of insurance benefits to Pediatric Partners. **Initial**_____

I HAVE READ AND UNDERSTAND AND BEEN GIVEN THE OPPORTUNITY TO RECEIVE A COPY OF THE FOREGOING TERMS, CONDITIONS, AUTHORIZATIONS AND CONSENTS AND HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS.

I UNDERSTAND THAT THE PROVISION OF HEALTH CARE SERVICES IS NOT AN EXACT SCIENCE AND ACKNOWLEDGE THAT NO GUARENTEES HAVE BEEN OR CAN BE MADE TO ME REGARDING THE RESULTS OF ANY EXAMINATION OR TREATMENT THAT MAY BE RENDERED TO ME DURING MY CLINIC VISIT.

I CERTIFY THAT I AM AUTHORIZED TO EXECUTE THIS DOCUMENT ON THE PATIENT'S BEHALF, AND I ACCEPT THE CONDITIONS OF SERVICE CONTAINED HEREIN.

_____ _____

Patient / Authorized Representative Signature Reason Patient is Unable to Sign

_____ _____ _____

Relationship to Patient (Witness) (Date)

Pediatric Partners Financial Policy

We would like to thank you for choosing Pediatric Partners as your pediatric medical provider. We want to assure you that we are very passionate about what we do and always strive to deliver the highest quality of pediatric medical care available. We are committed to providing this care in a caring compassionate and child friendly environment. So that we might focus more on what we do best…provide quality medical care to your child we have developed the following Financial Policy for Pediatric Partners effective as of August 1, 2008. Please read this Financial Policy carefully. Sharing this policy with you in advance allows for open communication which is paramount in maintaining a strong physician-patient relationship. Should you need clarification or have any questions, please do not hesitate to ask. We appreciate that you have put your trust in us regarding the care of your children and look forward to partnering with you in the health of your family and this community.

Patients with Insurance

Insurance is a contract between you, the patient (or parent) and the insurance company. Not all contracts are the same and not all insurance coverage is the same. The terms of your individual contract or plan determine the coverage or benefit that is available for treatments, procedures and or office visits. As a courtesy to you, we are glad to be able to assist you in obtaining the appropriate benefit from your individual insurance carrier by completing your insurance forms and filing them with your insurance administrator. To be successful we need your help to make sure that we have accurate and current insurance information.

Like anyone who provides a service we respectfully ask that the amount owed for the service be remitted promptly. Therefore, deductibles and co-payments are due at the time of service. Billing for these amounts later only increases the costs of healthcare and ultimately future insurance premiums and co-payments. As services are provided, we will bill your insurance carrier. In the event that your insurance carrier has not paid their portion within forty-five (45) days, the full balance becomes your responsibility. It is thereafter your responsibility to seek payment from your insurance carrier.

In order for our office to bill your insurance carrier *(Medicaid Patients excluded)*, **we require a valid credit card or debit card on file** with us. The security of your credit card information is important to us and will only be stored electronically with the credit card processor. Your credit card number is not physically stored in the clinic nor visible beyond the last four digits. Your credit card / bank account will not be charged until 30 days after the services provided have been processed by your health insurance carrier and/or the balance deemed your responsibility. We will attempt to notify you by statement and or letter at the address provided of any outstanding balances prior to Pediatric Partners charging your account or card at which time you may use a different form of payment to settle your account. By providing your card and receiving services, you are authorizing Pediatric Partners to charge your provided credit / debit card for any unpaid bills or claims.

Without a card on file or insurance, a refundable deposit or payment is due in full at the time services are rendered. **If a subsequent insurance payment results in a credit balance, we will promptly process a refund.**

Please note:

- Please present your current insurance card at each visit. If the insurance company or insurance card that you present is incorrect, you will be responsible for payment and submitting the charges to the correct plan.
- According to your insurance plan, you are responsible for any and all co-payments, deductibles and coinsurance.
- As you are party to the contract with your insurance carrier, it is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required and if pre-authorization is required prior to a procedure and what services are covered.
- If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, existing balances must be paid prior to the visit.
- If you do not have insurance, payment for an office visit is to be paid in full at the time services are rendered.
- Co-pays are due at time of service.
- We respectfully require 24 hours notice for canceling appointments.
- Before scheduling a Well Child Visit, check with your insurance company to verify whether they cover Well Visits and the amount of maximum benefits available. Not all plans cover annual Well Visits, physicals or hearing or vision screens. It is your responsibility to know your insurance plan benefits. If it is not covered you will be responsible for the payment at the time of the visit.
- Not all services provided by our office are covered by every plan. Any service determined not covered by your plan will be your responsibility.
- We are always willing to assist to the best of our ability in determining benefits, eligibility or your costs in advance