Family Information and Consent Form

PATIENT INFORMATION:

Child's Legal Name_____ Date of Birth_____ Sex Male / Female

Child's Legal Name_____ Date of Birth_____ Sex Male / Female

Child's Legal Name_____ Date of Birth_____ Sex Male / Female

Child's Legal Name_____ Date of Birth_____ Sex Male / Female

Primary Phone _____ Home / Cell Alternate Phone _____ Home / Cell

Primary Address_____ City_____ State_____ Zip_____

PARENT/GUARDIAN INFORMATION:

Guardian's Name_____ Relationship to patient?_____

Date of Birth_____ Is this person an authorized medical decision maker for the patient? Yes / No

Primary Phone Number_____ Home/Cell? Email Address_____

Address (If different from patient)_____ City_____ State_____ Zip_____

Employer_____ Work Phone_____

Spouse's Name_____ Phone Number_____

Guardian's Name_____ Relationship to patient?_____

Date of Birth_____ Is this person an authorized medical decision maker for the patient? Yes / No

Primary Phone Number_____ Home/Cell? Email Address_____

Address (If different from patient)_____ City_____ State_____ Zip_____

Employer_____ Work Phone_____

Spouse's Name_____ Phone Number_____

EMERGENCY CONTACT (NOT LIVING IN HOME)_____ PHONE NUMBER_____

INSURANCE INFORMATION : ***IN ORDER TO BILL INSURANCE, THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY***

Primary Insurance_____ Effective Date_____

Insurance ID Number_____ Group Number_____

Subscriber/Policyholder Name_____ Date of Birth_____

Relationship to patient_____ Address (if different from patient)_____

Secondary Insurance_____ Effective Date_____

Insurance ID Number_____ Group Number_____

Subscriber/Policyholder Name_____ Date of Birth_____

Relationship to patient_____ Address (if different from patient)_____

Office Policies

At Stapleton and Pearl Street Pediatrics our number one goal is to provide the best medical care for your child(ren). A part of that care is to provide and maintain a good provider-patient relationship. Letting you know in advance of our office policies allows for a good flow of communications and enables us, in part, to achieve that goal. All patients or their legal guardians must complete and sign the Office Policies form before being seen by a health care provider. Please read each section carefully and initial where indicated. If you have any questions, do not hesitate to ask a member of our staff

Financial Policy and Insurance Billing

You are responsible for your child's health care costs. We assist you with filing insurance claims to help you receive the maximum benefits allowed. Therefore, at the time of service, it is your responsibility to provide us with complete and accurate insurance information. If you do not have medical insurance, our staff will provide you with information regarding payment options.

Co-payments must be made upon check-in. We accept cash, checks, Visa, MasterCard, Amex and Discover. No post-dated checks will be accepted. For all returned checks, there will be a $35.00 return check fee. Co-payments are a contractual agreement between you and your insurance company, and Stapleton Pediatrics / Pearl Street Pediatrics cannot change or waive co-pays. In addition, there will be a $15.00 charge for non-payment

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of co-pays at the time of service. If you have any additional health concerns to discuss during a basic well exam, an office visit will apply and is subject to your insurance plan benefits and co-pay. Separate follow up visits with a provider are not included and are subject to your insurance plan benefits.

A current insurance card must be provided for verification. If you have changed insurance companies, please complete an Address/Insurance Information Update sheet.

I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number) regarding any matter related to my account by the practice or any entity to which assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account, as well as to the use of technology including auto-dialing and/or pre-recorded messages in contacting me. Please notify us immediately of any address and/or phone number changes.

Payment for medical care may be your responsibility if your insurance company does not pay or does not cover the services provided for you or for your child. Please be aware that we may provide services that your insurance may deny as "not covered." We suggest that you review the terms of your policy in full so that you understand which services are covered and which are not. If you have questions regarding your policy, please contact your insurance company, as we cannot be responsible for knowing the specifics of each patient's insurance plan. Please determine the extent of coverage and potential for personal liability before we provide services.

We allow 60 days from the date of service for the insurance company to pay their portion of the office bill and the next 30 days for you to pay your portion of the bill. Interest at a rate of 18% per annum, with a $3.00 monthly minimum charge, will be assessed on balances of 90 days or older.

If your account is placed for collections with an agency and/or attorney, the undersigned Responsible Party agrees to pay all costs of collection including, but not limited to, court costs, reasonable costs of collection charge by the agency and /or attorney, and reasonable attorney's fees, as permitted by statue or court judgement.

In accordance with national billing guidelines, a $50.00 charge will be billed for services performed on Saturdays, Sundays, after normally scheduled hours or for unscheduled walk-in appointments. These charges may be adjudicated in full or part by your insurance company.

Initials _____

NO SHOW / CANCELLATION POLICY: Our goal is to accommodate all of our patients' health care needs and schedules to the best of our ability. Therefore, we maintain a 24-hour cancellation policy to ensure all available appointment times can be utilized for patient care. If you fail to notify us of a cancellation, or notify us with less than 24 hours notice, you will receive a written warning. This will include a signed statement that you have reviewed and understand our cancellation policy. For a second offense, you will be charged a $25.00 cancellation fee. If three appointments are missed with improper notice, you may be dismissed from the practice.

Please note that "reminder" calls are made by our practice as a courtesy to our patient families. Failure to receive a reminder call does not eliminate the No Show/Cancellation Policy requirements.

LATE POLICY: If you are more than ten minutes late for a "well-care" or "physical" appointment, you will be considered a "No-Show" and may be asked to reschedule your appointment. In addition, our "No-Show" policy will be instituted. If you are more than five minutes late for a "sick" visit, we will make our best effort to see you in a timely fashion; however, patients who are on time for their appointments will be given priority and late patients will be seen only if time permits. You may also request to reschedule for an appointment later in the day, and we will do our best to accommodate your needs.

RECORDS TRANSFER AND COPIES OF RECORDS: Currently, the Colorado Department of Public Health and Environment regulations governing patient access to medical records from licensed health institutions, facilities, or health care providers mandates that the maximum allowable charge cannot exceed $14.00 for the first ten or fewer pages, $0.50 per page for pages 11-40, and $.33 per page for every additional page without Department approval. Actual postage or shipping costs and applicable sales tax, if any, also may be charged. No fees shall be charged by a health care provider for patient records requests received from another health care provider solely for the purpose of providing continuing medical care to a patient.

HIE: We support the secure electronic exchange of health information as a means to improve the quality of your health care experience. We participate in Colorado Regional Health Information Organization (CORHIO), Colorado Immunization Information System (CIIS), as well as insurance, pharmacy, and lab clearinghouses. Using Health Information Exchange (HIE) networks helps us to more effectively and efficiently share information about your medical care with other providers that participate in the network.. You may choose to opt-out of participation in the HIE, or cancel or opt-out at any time. Please speak with one of our staff members if you choose to opt-out.

Phone message consent: By filling in the information below you will be allowing us to leave medical information on YOUR answering system at the designated number(s). You may also allow us to leave a message regarding medical information with a designated person other than patient, parent or legal guardian. I fully understand that it is my responsibility to notify our office(s) with any changes in my contact information and this will remain in effect until revoked in writing.

Name: _____ Relationship to Patient: _____ Phone number: _____

Name: _____ Relationship to Patient: _____ Phone number: _____

Assignment and Release

I, the undersigned, acknowledge the child(ren) have insurance coverage and assign directly to the physicians of Stapleton Pediatrics or Pearl Street Pediatrics all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether of not paid by insurance. I hereby authorize the release of all information necessary to secure the proper payment of benefits. I authorized the use of this signature on all insurance claims.

HIPAA

I, the undersigned, acknowledge the receipt and have reviewed the Notice of Privacy Practices and agree to its provisions. A paper copy of our Notice of Privacy Practices is available upon request.

Consent for treatment: I, the undersigned, voluntarily agree to the test, procedures and/or treatments which the health care provider deemed necessary and which are administered to or performed on my child.

I have read, fully understand, and agree to all terms set forth in the above Office Policies.

_____ _____

Printed Name of Responsible Party **Relationship to Patient**

_____ _____

Signature of Responsible Party **Date Signed**