Patient Information

Patient Information:

Child's Last Name: _____ First Name: _____ MI___ Sex: M F

Child's DOB: ___/___/___ SSN: ____-___-____ Primary Ph: (___) ___-_____ Cell Ph: (___) ___-____

Primary Address: _____

(Street) (City) (State) (Zip code)

Mailing Address: _____

(P.O. Box) (City) (State) (Zip Code)

Who lives at this household? _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Primary Language: _____

Parent/Guardian Information:

Mother: Name: _____ Mother's Maiden Name: _____

Date of Birth: ___ / ___ / ___ Social Security #: _____ - _____ - _____

Work Phone: (___) _____ - _____ Cell Phone: (___) _____ - _____

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

Lives with patient? Yes/No If no, please list the address:

_____

_____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: No Contact /Home Phone / Work Phone / Cell Phone / Text Cell Phone/ Home Email

Appointment Reminders: No Contact / Home Phone / Cell Phone / Text Cell Phone/ Home Email / Work Email

Recall Notices: No Contact / Home Address / Home Phone / Work Phone / Cell Phone / Text Cell Phone / Email

Billing Statements: No Contact / Home Address / Home e-mail

General Practice Notices: No Contact /Home Address / Home Phone / Cell Phone / Home Email

Patient Portal Notifications: No Contact /Cell Phone / Text to Cell Phone / Home Email / Work Email

Father: Name: _____ Date of Birth: ___ / ___ / ___

Social Security #: ___ - ___ - ____ Work Phone: (___) _____ - _____ Cell Phone: (___) _____ - _____

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

Lives with patient? Yes/No If no, please list the address:

_____

_____

How would you ideally prefer to be contacted regarding (circle one):

Medical Issues: No Contact /Home Phone / Work Phone / Cell Phone / Text Cell Phone/ Home Email

Appointment Reminders: No Contact / Home Phone / Cell Phone / Text Cell Phone/ Home Email / Work Email

Recall Notices: No Contact / Home Address / Home Phone / Work Phone/ Cell Phone / Text Cell Phone /Email

Billing Statements: No Contact / Home Address / Home e-mail

General Practice Notices: No Contact /Home Address / Home Phone / Cell Phone / Home Email

Patient Portal Notifications: No Contact /Cell Phone / Text to Cell Phone / Home Email / Work Email

Emergency Contacts, <u>other than parents</u>: Name & Relationship

1: _____ *Phone*: (_____) _____ - _____

2: _____ *Phone*: (_____) _____ - _____

Please list the name and relationship of the person(s) that you authorize to release information to:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Please list the name and relationship of the person(s) that you authorize to bring your child/children to appointments and to act on your behalf in the treatment of your child/children.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Insurance Information (Please complete even if we have a copy of the insurance card):

Primary: _____ Policy Holder Name: _____ DOB: __/__/___

SSN: ___-__ - ___ Relationship to patient: _____

Policy/ID: _____ Group #: _____ Group Name: _____

Effective date: ___/___/___ Claims address: _____

Phone number: (___) ___- ____

Secondary Insurance: _____Policy Holder Name: _____ DOB: ___/___/___

SSN: ___-__ - ___ Relationship to patient: _____

Policy/ID: _____ Group #: _____ Group Name: _____

Effective date: ___/___/___ Claims address: _____

Phone number: (___) ___- ____

Who should receive billing statements? _____

If parents are divorced or separated please fill out 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.

_____
_____
_____

Consent:

I hereby grant permission for the Physician of Harvey Pediatrics, LLC to perform, or order the performance of, any medical treatment they deem necessary, including testing for infectious disease. Harvey Pediatrics, LLC is not responsible for acts performed pursuant to the instructions from the Physicians. I understand that during treatment, the Physicians may request that other providers render professional services on the patient's behalf. I understand that payment for all professional services is my responsibility, regardless of insurance coverage of the status of any insurance claim. I hereby give my consent to any insurance carrier to release information regarding the status of claims to Harvey Pediatrics, LLC. I authorize Harvey Pediatrics, LLC to furnish information to any insurance carrier concerning the patient's medical history, illnesses, and treatments. I hereby authorize insurance benefits including major medical, Medicaid, private insurance and/or any other health plan benefits to which I, my spouse, or my dependents are entitled be paid directly to Harvey Pediatrics, LLC I hereby authorize Harvey Pediatrics, LLC to release all information necessary to secure the payment(s) of these benefits. A photocopy of this assignment shall be considered as valid as the original. This assignment will remain in effect until revoked by me in writing.

_____ (Initial) I understand that payment for all professional services is my responsibility, regardless of insurance coverage of the status of any insurance claim. I understand that it is customary to pay for services at the time they are rendered unless other arrangements have been made in advance. I understand that in the event of a returned check, a $35 additional will be charged.

_____ (Initial) In the event the account is assigned to a collection agency, I agree to pay all costs of collection, including reasonable attorney fees. *Any charges or costs paid to a billing and/or collection agency to recover properly billed charges will be added to the total and that these additional charges will often make the total amount due to be higher than the original charge: this situation can best be avoided through cooperation and timely payment of charges due.*

_____ (Initial) I give my consent for Harvey Pediatrics, PLLC to obtain medication history when prescribing medications.

_____ (Initial) I understand that a $50 fee will be charged in the event that 24 business hours were not given to cancel an appointment or for missed appointments.

I grant permission for Harvey Pediatrics or an outside party on behalf of Harvey Pediatrics, to contact me for appointment reminders. I acknowledge that I have received the Harvey Pediatric information handout.

I have read and understand these policies.

Signature: _____ Date: _____