PLEASE NOTE: We will be unable to bill your insurance if we do not receive this paperwork back completed in its entirety and have a copy of your current insurance card on file.

Indian Crest Pediatrics

DATE _____

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

Race_____ Ethnicity Hispanic / Not Hispanic

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)_____

AUTHORIZATION FOR TREATMENT: I (we) give the following people permission to bring our child in for treatment (i.e. grandparent, nanny, etc.).

Name_____ Relationship to Patient_____ Initials_____

Name_____ Relationship to Patient_____ Initials_____

CONTINUED ON OTHER SIDE

Indian Crest Pediatrics

PLEASE NOTE: We will be unable to bill your insurance if we do not receive this paperwork back completed in its entirety and have a copy of your current insurance card on file.

DATE _____

Financial Policy

You are responsible for your child's healthcare costs. It is important to become familiar with your specific insurance plan. If you have questions, please contact your insurance company or employer directly. It is also important to realize that health insurance policies rarely cover all medical costs and that patients are usually responsible for a portion. Health insurance is a contract between you and your insurance company. You are still responsible for any services rendered on your child's behalf. We realize that many families are in a state of change. Divorced, separated, single parent and blended families are common. In many of these families, the question of who is responsible for the children's medical bills is uncertain. **Our policy is that the parent who brings in the patient is ultimately responsible for all fees incurred,** unless other arrangements are made with our office in writing. We will bill your insurance company providing we are contracted with them and that you provide us with information at each visit regarding your current plan. Current insurance cards MUST be presented at each visit. Copayments are due on the date services are rendered. All copayments not received on the date of service are subject to an additional fee. Patients without insurance/"self pay" are required to pay in full at the time of service. All balances over 60 days are considered past due and will be handled appropriately. Payment plans are available through our billing office.

1. I understand that payment for charges is due on the date of service with the exception of insurance carriers for which Red Rocks Pediatrics is under contract to file directly.
2. I understand that my insurance coverage may not provide payment for all charges incurred in obtaining treatment from Red Rocks Pediatrics. I will be responsible for any copayment, deductible or services not covered by my insurance provider. If I do not have insurance coverage for services rendered by Red Rocks Pediatrics, I agree to pay all charges resulting from such services.
3. I hereby authorize Red Rocks Pediatrics to file with my insurance carrier, and I assign payment of medical benefits to Red Rocks Pediatrics.
4. I authorize release of any and all medical records and information necessary to process any claim generated by services I receive in this office.
5. I will keep my account current as to charges for which I am responsible. In the event that I fail to pay charges, Red Rocks Pediatrics is entitled to take whatever action necessary to collect such charges, and I will be responsible for reasonable attorney fees and costs incurred as a result of such collection. I understand that those accounts on a payment plan that are not kept current are subject to further action.
6. I understand that Red Rocks Pediatrics, PC is closed to new patients with state-funded insurance including Medicaid. If it is determined that a family member is found to have coverage, I will be assisted in finding a new medical home for my family that is accepting new patients with state insurance.
7. I understand that all missed appointments are subject to a fee not billable to my insurance. A 24-hour advanced notice is required to cancel an appointment unless it is made the same day. Appointments made the same day require a 4-hour cancellation notice.

HEALTH INFORMATION EXCHANGE: Indian Crest Pediatrics endorses, supports and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice at any time.

CONSENT TO COPY MEDICAL RECORDS: I understand that it may be necessary for other healthcare providers to review information in my child's medical record in order to render medical care to my child. I authorize Red Rocks Pediatrics to copy part or all of my medical record in the event that it is needed by another healthcare provider in order to provide medical treatment.

CONSENT FOR TREATMENT: I, the undersigned, voluntarily agree to the tests, procedures and/or treatments which the attending physician has deemed necessary and which is administered to or performed on my child under the direction of the attending physician and his/her designees.

CONSENT TO E-MAIL: I understand that there may be times that the providers and/or staff of Indian Crest Pediatrics may request e-mailed documentation. **I understand that E-mail communication should NOT be used for general, emergent or urgent messages as it is not monitored on a daily basis.** I understand that I need to contact the office for appointment requests and medical questions. I understand that electronic communication is not secure.

My signature indicates that I have read and agree to ALL terms set above.

Signature of patient/parent/legal guardian_____ **Date**_____

PHONE MESSAGE CONSENT: There may be times when a physician or staff member may need to contact **YOU** with medical information (including but not limited to lab results, referral information and appointment information) via telephone. 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 (i.e. grandparent or daycare provider, etc.) other than patient, parent or legal guardian (if patient less than 18 years of age). I fully understand that it is my responsibility to notify Indian Crest Pediatrics with any changes in my contact information and this will remain in effect until revoked in writing.

Name _____ Relationship to Patient_____ Phone Number_____Initials _____

Name _____ Relationship to Patient_____ Phone Number_____Initials _____

HIPAA POLICY: The undersigned patient or legally authorized representative of the patient acknowledges that he or she personally received or was offered a copy of the Indian Crest Pediatrics Privacy Policy on the date indicated below.

Printed Name _____ Relationship to Patient_____

Signature _____ Date_____

OFFICE USE ONLY: We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason: _____

UPDATED 8/4/17

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