**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 _____

**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

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_____

Preferred Method of Communication: TEXT MESSAGE or VOICE MESSAGE

**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_____

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

Name_____ Relationship to Patient_____Initials_____

Name_____ Relationship to Patient_____Initials_____

Name_____ Relationship to Patient_____Initials_____



**CONTINUED ON OTHER SIDE**

**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 INFORMATION

**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)_____

**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 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, except for 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 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 because 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.

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

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

**I have reviewed the above demographic and insurance information and confirm that all information is still current.**

**Date** _____ **Signature** _____

**Relation** _____

**For Employee Use:** Verified/Updated on _____ Initals _____

**Date** _____ **Signature** _____

**Relation** _____

**For Employee Use:** Verified/Updated on _____ Initals _____



**CONTINUED ON OTHER SIDE**