PATIENT'S INFORMATION

PATIENT NAME

Name _____ _____ _____
Last First Middle

Address _____ _____ _____
Number Street Apt#

_____ _____ _____
City State Zip

Ethnicity _____

Birth Date _____ _____ _____
Month Date Year

Social Security # ____ ____ ____ - ____ ____ - ____ ____ ____ ____

Gender _____ _____
Male Female

MOTHER'S (OR GUARDIAN'S) INFORMATION

MOTHER NAME

Name _____ _____ _____
Last First Middle

Address _____ _____ _____
Number Street Apt#

_____ _____ _____
City State Zip

Phone _____ _____
Home Cell/Work

Birth Date _____ _____ _____
Month Date Year

Social Security # ____ ____ ____ - ____ ____ - ____ ____ ____ ____

FATHER'S (OR GUARDIAN'S) INFORMATION

FATHER NAME

Name _____ _____ _____
Last First Middle

Address _____ _____ _____
Number Street Apt#

_____ _____ _____
City State Zip

Phone _____ _____
Home Cell/Work

Birth Date _____ _____ _____
Month Date Year

Social Security # ____ ____ ____ - ____ ____ - ____ ____ ____ ____

STEP-MOTHER'S INFORMATION

STEPPARENT/GUARDIAN

Name _____ _____ _____
Last First Middle

Address _____ _____ _____
Number Street Apt#

_____ _____ _____
City State Zip

Phone _____ _____
Home Cell/Work

Birth Date _____ _____ _____
Month Date Year

Social Security # ____ ____ ____ - ____ ____ - ____ ____ ____ ____

STEP-FATHER'S INFORMATION

STEPPARENT/GUARDIAN

Name _____ _____ _____
Last First Middle

Address _____ _____ _____
Number Street Apt#

_____ _____ _____
City State Zip

Phone _____ _____
Home Cell/Work

Birth Date _____ _____ _____
Month Date Year

Social Security # ____ ____ ____ - ____ ____ - ____ ____ ____ ____

FAMILY INFORMATION

Patient lives with (check all that apply):
_____ Mother
_____ Father
_____ Step-mother
_____ Step-father
_____ Other (please specify) _____

If you are interested in using your e-mail address, please list here:

Sibling's in household (include patient): Birth dates

_____ ____/____/____
_____ ____/____/____
_____ ____/____/____
_____ ____/____/____
_____ ____/____/____
_____ ____/____/____
_____ ____/____/____

EMERGENCY CONTACT PERSON
(OTHER THAN PARENT OR STEP-PARENT)

Name_____

Phone_____

PRIMARY INSURANCE INFORMATION

INSURED PARTY'S NAME_____

INSUREDPARTY'S BIRTHDATE_____/_____/_____

INSURED PARTY'S SS #_____ - _____ - _____

INSURED PARTY'S RELATIONSHIP TO PATIENT
____Parent ____Step-parent ____Other (_____)

INSURANCE COMPANY_____

POLICY NUMBER_____

GROUP NUMBER_____

INSURED PARTY'S EMPLOYER_____

SECONDARY INSURANCE INFORMATION

INSURED PARTY'S NAME_____

INSUREDPARTY'S BIRTHDATE_____/_____/_____

INSURED PARTY'S SS #_____ - _____ - _____

INSURED PARTY'S RELATIONSHIP TO PATIENT
____Parent ____Step-parent ____Other (_____)

INSURANCE COMPANY_____

POLICY NUMBER_____

GROUP NUMBER_____

INSURED PARTY'S EMPLOYER_____

PLEASE READ CAREFULLY

CONSENTS AND DISCLOSURES: I voluntarily consent to treatment of myself and/or my dependents by medical healthcare providers of *Peak Pediatrics, LLC*.

CO-PAY POLICY: It is your responsibility to know how much your co-pay is. If you are unsure please contact your insurance company by dialing the customer service number located on your insurance card. **All co-pays are due at time of service, and a $10.00 administrative fee will be charged for any co-pay not paid at every visit**.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: I understand that I am financially responsible and agree to pay all of the charges that are not paid by insurance. I authorize the submission of claims without obtaining my signature on each and every claim submitted. I authorize payment directly to *Peak Pediatrics, LLC* for all benefits otherwise payable to me. Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I understand that I am responsible for all costs of collection including attorney fees, collection fees and courts costs. I also understand that any unpaid balance may be assessed interest at the rate of 18.00% (1.5% monthly).

RELEASE OF INFORMATION: I authorize *Peak Pediatrics, LLC* to release (verbally or in writing) confidential medical information to any person or entity which may be liable to me or my Practitioner(s) for charges rendered for treatment; and for quality management, utilization review, transfer and follow-up purposes. I also understand that a copy of this agreement may be used with the same effectiveness as the original.

INSUFFICIENT CANCELLATION AND NO-SHOW POLICY: *Peak Pediatrics, LLC* **requires twenty-four hours notice should you need to cancel or reschedule a Well Child visit, and two hours notice for an Acute visit**. You may be charged a mandatory fee for any appointment that is not cancelled as outlined above.

I hereby authorize this provider and its employees, agents and assignees to contact me via e-mail, text messaging and to my cellular devices.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

*****On behalf of _____ DOB_____*****

I understand that a copy of **PEAK PEDIATRICS, LLC** Notice of Privacy Practices is available upon request from any reception desk or medical service provider at any time for my review, which is recommended.
I also understand that for each patient, this office is required to keep a log of all disclosures of PHI for non-TPO reasons for which you did not provide written authorization.

SIGNING BELOW MEANS YOU HAVE READ AND UNDERSTOOD THE OFFICE POLICIES OF *PEAK PEDIATRICS, LLC.*

Signature of Patient/Guardian:_____Date:_____