

Pediatric Associates Patient Introduction Slip

Date _____

Date of Birth: _____

Patient Name: First _____ Middle _____ Last _____ (Male/Female)

Address: _____ City: _____ State _____ Zip _____

Father's Name: _____ Employer: _____

Father's Address (if different): _____

Mother's Name: _____ Employer: _____

Mother's Address (if different): _____

Phone Numbers: Please list in order of preference for when we need to contact you (e.g. Reminders for Appointments)

Preferred #: (Mom/Dad/Patient) + (Home/Cell) _____ Mom's Work _____

2nd Phone #: (Mom/Dad/Patient) + (Home/Cell) _____ Dad's Work _____

3rd Phone #: (Mom/Dad/Patient) + (Home/Cell) _____

Preferred Email Address: _____

Nearest Friend or Relative: _____ Phone: _____

Name of Insurance Company _____ Insured or Responsible Parent: _____

Subscriber ID#: _____ Group #: _____

Mother's Social Security # _____ Father's Social Security # _____

Insured DOB: _____ Insured Employer: _____

Credit – Financial Policies

Welcome to Pediatric Associates. Please Take a few minutes to review the following information. Please sign the Credit Policy and the Receipt of Notice of Privacy Practices. We hope you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain this medical office for our patient and the community.

Charges for medical services at our office are due and payable at the time services are rendered. We don't give a discount when paying at the time of service. We accept cash, checks, Visa, MasterCard and Discover. For in-hospital services provided by our physicians we will submit the charges to your insurance and allow 45 days for payment. At that time you are required to pay the charges and then settle with your insurance company. If you have health insurance, please understand that this is an agreement between you and your insurance company to pay a certain amount for your medical care. Our bill for medical service is an agreement between you and our office. You are responsible for the payment of your bill regardless of the status of your insurance claim (unless you are with an HMO insurance plan).

If unusual circumstances should make it impossible to meet our credit terms, please call or personally discuss the matter with our office manager. This will avoid misunderstanding and enable you to keep your account in good standing. Accounts 90 days past due are referred to a collection agency, unless prior arrangements have been made with our office. In the event that your account is turned over to collection you will be responsible for the collection fee in addition to your balance. Also, we will no longer be your primary care physician. In order to keep your appointments on time it has become necessary for us to charge extra for walk-in and unscheduled appointments (each child to be seen must have an appointment time). If you are unable to keep your appointment, please cancel within 24 hours or you may be charged a fee. There is a charge for after-hours phone calls: however, no charge is assessed if the child is seen on the next business day. If you should have and question regarding our office policy please feel free to discuss it with our office manager.

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practice of Pediatric Associates

I received a copy of the Notice of Privacy Practices for Pediatric Associates. This notice describes how Pediatric Associates may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Name of Patient: _____

Signature of Patient or Patient Representative: _____

Relationship of Patient Representative of Patient: _____ Date: _____

(Pediatric Associates reserves the right to modify the privacy practices outlined in this notice.)

Birth History – Please Complete:

Birth Weight: _____ Length: _____ Gestation: _____
Hospital: _____ Obstetrician: _____
Mother's Age At Birth: _____ Number of Previous Children: _____
Any Pre-Natal Maternal Health Problems? No Yes _____
Any Post-Natal Maternal Health Problems? No Yes _____
Any Nursery Problems? No Yes _____

Date of Last Complete Physical _____

How did you hear about our office?

- OB/GYN _____ Physician _____ Yellow Pages _____
- Friends _____ Internet _____ Other _____
- Sibling _____ Insurance _____

Have there been any shot reactions? Y / N If yes please explain: _____

Past Medical History – Please Complete: Has your child ever

had: Allergies: No Yes (Type) _____

Asthma: No Yes

Bladder Infections: No Yes

Chicken Pox: No Yes

Diabetes: No Yes

Diarrhea, Severe: No Yes

Ear Infections, Frequent: No Yes- How many? _____

Heart Disease: No Yes

Infectious Mononucleosis: No Yes

Any Hospitalizations: No Yes

Explain _____

Any Surgeries: No Yes

Explain _____

Kidney Disease: No Yes

Liver Disease: No Yes

Pertussis: No Yes

Pneumonia: No Yes

Rheumatic Fever: No Yes

Rubella: No Yes

Scarlet Fever: No Yes

Recurrent Tonsil Infections: No Yes

Seizures: No Yes

If **yes** to any, please explain _____

Family History – Please Complete:

Mother's Name _____	Age _____	Health _____
Father's Name _____	Age _____	Health _____
Siblings _____	Age _____	Health _____
_____	Age _____	Health _____
_____	Age _____	Health _____
_____	Age _____	Health _____
_____	Age _____	Health _____

Is there a family history on either Mother's or Father's side of:

Allergy: No Yes

Diabetes: No Yes

Heart Problems: No Yes

Lung Problems: No Yes

Kidney Problems: No Yes

Intestinal Problems: No Yes

Thyroid Problems: No Yes

Blood Disorders: No Yes

Glandular Problems: No Yes

Psychiatric Problems: No Yes

Seizures: No Yes

Other _____

*** I authorize the release of any medical or other information necessary to process insurance claims, school and daycare forms, Every Child By Two program and for referral appointments. ***

Signature: _____ Date _____

Authorization To Use Or Disclose My Health Information

Patient Name: _____ Date of Birth: _____

I hereby authorize _____
Name Address City State Zip

To release information for my medical record as indicated below to:

Name: **Pediatric Associates of Fort Collins** Address: **2001 S. Shields St. Bldg G**

City: **Fort Collins** State: **CO** Zip: **80526** Phone: **970-484-4871**

I. My Authorization:

You may use or disclose the following health care information (check all that apply):

- All my health information maintained by the above named practice
(Circle include or exclude for each of the following)
Include or exclude: My health information related to drug abuse
Include or exclude: My health information related to alcohol abuse
Include or exclude: My health information related to HIV/AIDS
Include or exclude: My health information to psychological or psychiatric conditions, including psychotherapy notes.
- My health information relating to the following treatment or condition:

- My health information for the date(s): _____

Reason(s) for this authorization (check all that apply):

- At my request _____
- Other _____

This authorization ends:

- On (date) _____

II. My Right

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the entity which was originally authorized to disclose information.

Once the office discloses health information, the person or organization that receives it may re-disclose it.

Privacy laws no longer protect it.

Parent or legally authorized individual signature

Date

Print Name if signed on behalf of patient

Date

***When medical records have been received for the above patient, please date, sign and fax this form to (970) 482-4927.

Date Received: _____ Signature: _____