Academy Pediatrics P.A.
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Information Sheet (**please complete all sections**) Today's Date ___/___/___

PATIENT'S NAME _____ **DOB** ___/___/___ ☐**Male** ☐**Female**

ADDRESS _____ **APT**_____**CITY**_____**STATE**_____**ZIP**_____
HOME PHONE (____) _____ **PLACE of BIRTH** _____
SIBLINGS & AGES _____ _____ _____ _____

PARENT INFORMATION

Parent Name: _____ Email: _____

Address: _____ City: _____ State: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____
Parent Name: _____ Email: _____

Address: _____ City: _____ State: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Employer: _____

Emergency Contact (***other than parent***): Name: _____
Relationship: _____ Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

Primary Policy Holder: _____ D.O.B: ___/___/___ Relationship: _____
Social Security Number: _____ Insurance Co. Name: _____

Insurance Co. Address: _____ Phone Number: _____
Policy Number: _____ Group Number: _____
Co-pay Amount $_____ Policy Effective Date___/___/___

RESPONSIBLE PARTY/BILLING INFORMATION

Responsible Party Name _____ Relationship to Patient _____
Address_____ City _____ State_____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

We <u>do not</u> bill secondary insurance companies or insurance companies that we <u>do not</u> participate with.

PHARMACY INFORMATION

Name: _____ Address: _____

Phone Number: _____ Fax Number: _____

Assignments of Benefits
I, the undersigned, request that payment of all insurance benefits payable for medical services provided, be made directly to the physicians of Academy Pediatrics P.A. In addition, I authorize the release of any medical information, as permitted by the law necessary to process a health insurance claim form.

Parent/Guardian
Sign _____ Print Name _____ Date _____

Beneficiary Agreement

I do hereby acknowledge that I was informed that in the event that my health care insurance plan denies payment for services received at Academy Pediatrics P.A. I agree to be personally responsible for the payment of these services. It is therefore my responsibility to contact my insurance carrier to confirm the coverage provisions.

Parent/Guardian
Sign _____ Print Name _____ Date _____

Please be advised that there is a **24 hour cancellation policy**.
I understand that failure to adhere to this policy may result in a $75 missed appointment fee for well visits and $50 for all others. Initial _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 **(HIPAA**)

PATIENT NAME: _____ **PATIENT DOB:** _____

I hereby acknowledge that I was provided a copy of Academy Pediatrics' Notice of Privacy Practices have been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

COMMUNICATION AUTHORIZATION REQUEST AND PATIENT RECORD OF DISCLOSURES

I wish to be contacted in the following manner regarding my child/children (*please check all that apply)*

☐**Home Telephone**: _____

☐OK to leave a message with call back number

☐DO NOT leave a message

☐**Work Telephone**: _____

☐OK to leave a message with call back number

☐DO NOT leave a message

☐**Written Communications**

☐OK to mail to my home

☐OK to fax to (home only) _____

☐OK to email to this address _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual. Healthcare entities must keep records of PHI disclosure.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name of Patient's Representative (if applicable) Relationship to Patient

- **FOR OFFICE USE ONLY** ---------- If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____

FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. Academy Pediatrics P.A. accepts cash, personal check (in-state only), VISA and MasterCard.

There is a service charge of $50.00 for returned checks. Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments.

REFUNDS

Overpayments will be refunded upon written request to the responsible party within 30 days.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.
I have read and understand the Academy Pediatrics P.A. Financial Policy. I agree to assign insurance benefits to the Academy Pediatrics P.A. practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the 30% charged by the collection agency for costs of collections.

Signature of insured or authorized representative: _____
Print Name:_____ Date: _____

☐Please remember, it is <u>your</u> responsibility to have an understanding of the benefits your insurance company offers.