Pediatric Partners of the Southwest

It's very important that we have your Patient/Family information correct – PLEASE PRINT CLEARLY

PRIMARY CONTACT PERSON FOR FAMILY (this person will be the **preferred contact person** for Reminder calls)

Check one:_____Birth Mother_____Stepmother_____Adoptive Mother_____Foster Mother_____Legal Guardian Other:_____

Birth Father_____Stepfather_____Adoptive Father_____Foster Father_____

Name:_____DOB:_____/_____/_____SS#:_____-_____-_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Work Phone: _____

E-mail:_____ Do you live with the patient? __Yes__No

Please check preferred means of contact for messages:_____Home_____Cell_____Work_____E-mail

SECONDARY CONTACT PERSON FOR FAMILY

Check one:_____Birth Mother_____Stepmother_____Adoptive Mother_____Foster Mother_____Legal Guardian Other: _____

Birth Father_____Stepfather_____Adoptive Father_____Foster Father_____

Name:_____DOB:_____/_____/_____SS#:_____-_____-_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Work Phone: _____

E-mail:_____ Do you live with the patient? __Yes__No

WHO HAS PRIMARY PHYSICAL CUSTODY? _____

EMERGENCY CONTACT PERSON (other than either the parent/s or contact/s listed above)

Name:_____Relationship to patient:_____Phone:_____

PERSON/S AUTHORIZED TO BRING PATIENT TO PPSW FOR TREATMENT (besides parents)

Name/s:_____Relationship: _____

LIST ONLY CHILDREN THAT THE ABOVE INFORMATION APPLIES TO

(If children have a different family dynamic than above, they must have a different sheet)

	FIRST CHILD	SECOND CHILD	THIRD CHILD	FOURTH CHILD
FIRST NAME				
LAST NAME				
GENDER				
DOB				
Primary Language	____ English____Spanish Other: _____	___ English____Spanish Other: _____	___ English____Spanish Other:_____	___ English____Spanish Other: _____
Ethnicity	____Not Hispanic or Latino ____Latino ____Hispanic Mexican ____Hispanic Cuban ____Hispanic Puerto Rican ____Hispanic Other	____Not Hispanic or Latino ____Latino ____Hispanic Mexican ____Hispanic Cuban ____Hispanic Puerto Rican ____Hispanic Other	____Not Hispanic or Latino ____Latino ____Hispanic Mexican ____Hispanic Cuban ____Hispanic Puerto Rican ____Hispanic Other	____Not Hispanic or Latino ____Latino ____Hispanic Mexican ____Hispanic Cuban ____Hispanic Puerto Rican ____Hispanic Other
Race (check all that apply)	____ Native American *Tribal/Census #- _____ ____ Black ___ White ____ Asian ___ Pacific Islander ____	____ Native American *Tribal/Census #- _____ ____ Black ___ White ____ Asian ___ Pacific Islander	____ Native American *Tribal/Census #- _____ ____ Black ___ White ____ Asian ___ Pacific Islander	____ Native American *Tribal/Census #- _____ ____ Black ___ White ____ Asian ___ Pacific Islander
Can patient be seen w/out parents if under 18?	____ Yes____No	____ Yes____No	____ Yes____No	____ Yes____No

Would you like a copy of our HIPAA Privacy Practices? (Circle one) Yes Received (please initial)_____ No

Parent/Guardian Signature:_____ Date: _____

INSURANCE INFORMATION

WHO IS THE FINANCIAL GUARANTOR? – THIS IS THE PERSON WHO WILL RECEIVE BILLING STATEMENTS IN THE MAIL.
(Parents must agree on this and work arrangements out among themselves for payment issues. Pediatric Partners will not become involved with domestic disagreements over who receives Billing Statements.)

Printed Name:_____Relationship to patient/s: _____

Address:_____ City:_____State:_____Zip:_____ Home

Phone:_____Cell Phone:_____DOB:_____/_____/_____

Do you live with the patient?_____Yes_____No SS#:_____-_____-_____

WHO CARRIES PRIMARY INSURANCE

Name:_____DOB:_____/_____/_____Best phone # to contact you: (_____)_____-_____

Name of Ins. Company:_____Policy #:_____Group #: _____

Do you live with the patient?____Yes____No Relationship to patient: _____

WHO CARRIES SECONDARY INSURANCE

Name:_____DOB:_____/_____/_____Best phone # to contact you: (_____)_____-_____

Name of Ins. Company:_____Policy #:_____Group #: _____

Do you live with the patient?____Yes____No Relationship to patient: _____

OFFICE POLICIES

Initial I understand that both birth parents have access to full disclosure, even if they are not the custodial parent, and both can authorize care representatives, unless parental rights have been terminated by court order. I understand that if there are custody orders in place, I must present current copies for my child's file. I authorize the people listed therein to bring my child to any appointments in the event of my absence, and give Pediatric Partners of the Southwest, herein referred to as PPSW, permission to call and leave a message regarding my child's clinical care, including lab and x-ray results, in my absence.

Initial_I authorize PPSW to fax any forms or immunization records to my child's school upon my request.

Initial_____A copy of our Privacy Practice Notice will be made available to you upon request. By signing below, you acknowledge that you have had the opportunity to request to read, or receive a copy, of the Privacy Practice Notice of PPSW.

Signature:_____**Date:**_____

Name of child/ren:_____

CREDIT CARD PAYMENT AUTHORIZATION

To facilitate the billing process, Pediatric Partners of the Southwest (PPSW) has implemented a credit card payment system. Our goal is to assist our patients in eliminating past due accounts. The advantage of this program is that you will no longer need to submit checks by mail or have to worry about any past due account balances. This will in no way compromise your ability to dispute charges, or, question your insurance company's determination of patient responsibility balances and charges subsequently processed to your card.

Initial Once your "Explanation of Benefits" has been received from your insurance, **any remaining balance your insurance company states is owed by you as "patient responsibility" will be charged to the Credit/Debit card referenced below**. These charges will not exceed $75.00 per transaction, unless the account balance is over 90 days old. A receipt of those charges will then be mailed to you once this charge is posted to your Credit/Debit card.

____ Visa_____MasterCard ____Debit_____Credit Card Is this card attached to an HSA/HRA account?_____Yes_____No

Name on Card:_____ Card #:_____Expiration Date:_____/_____

_____ I DO NOT WANT MY CARD ON FILE

Patient Name: _____

Signature: _____

Signature is required whether you choose to keep a card on file or not

Revised 10/27/2020 ADR

FINANCIAL RESPONSIBILITY

In agreeing to be responsible for your medical care, Pediatric Partners of the Southwest (PPSW) requires that you please read carefully and initial where indicated, acknowledging your understanding and acceptance of your financial obligation to us.

Initials_____Authorization to treat: I consent to examination and treatment by the personnel at PPSW for my child or other dependents. This will remain in effect from this date forward unless written revocation of such is received.

Initials_____Authorization to release information and assignment of benefits: I hereby authorize the physician to release any information acquired in the course of my child's/ren's treatment necessary to process insurance claims.

Initials_____Authorization to pay benefits to physician: I hereby authorize payment directly to the physician for surgical and/or medical benefits, if any, that are otherwise payable to me for services rendered, realizing that I am responsible for all co-pays, deductibles, and non-covered services as determined by my insurance plan.

Initials_____Insurance plans: I understand that it is my responsibility to confirm with my insurance company that the physician is currently under contract with my plan, or be willing to be seen at "out of network" benefits. Any questions about medical, well baby/preventive care, labs/x-rays, and immunization coverage, should be directed to my insurance carrier prior to my visits. I agree to be held responsible for all co-pays, deductibles, and non-covered services as determined by my insurance plan.

Initials_____Payments: I guarantee that I will promptly pay all amounts that have been determined my responsibility by my insurance plan upon receipt of my statement. I understand that my health insurance contract is between my insurance company and myself. If my insurance does not pay for the services rendered by the practice doctors within 45 days the practice may look to me for payment. The practice agrees to refund any over payment that I have made on my account, in the event that my insurance eventually pays. Any balance remaining after my insurance pays, denies, applies to my deductible, or deems to be a non-covered benefit under my plan, will be my responsibility. **If I have not paid my bill, or have not arranged for a payment plan, the practice may ask for the assistance of an outside collection agency. If my account is turned over to a collection agency, I will be dismissed from the practice and no longer receive medical care from PPSW. I understand that the practice will work with me to avoid this.**

Initials_____Saturday Clinic charge: There is an additional $50.00 facility fee for Saturday Clinic visits. PPSW will be happy to bill this to your insurance, but some policies do not cover this fee. You will be billed the total amount your insurance does not pay.

Initials_____Credit card on file: PPSW recommends all parents leave a credit card number on file with our office. You can be assured your information is secure. The card may be used as a convenient solution to paying your account balance and will be used for those patient accounts that are past due and attempts to contact the financially responsible party have been unsuccessful. See attached credit card authorization form.

Initials_____Check in: Co-pays and past due balances are due at time of check in. Please come prepared to pay. Regardless of who brings your child in for patient services, payment is expected. Payment collection will not be delayed for any reason. If you do not have your co-pay, or have not come prepared to pay any past due balances, the appointment may be rescheduled until such a time that you can fulfill your financial obligation. Please bring your most current insurance card with you at each visit. For all visits, we will ask you to verify that your insurance and demographic information in our records is correct.

Initials_____Appointments and late arrivals: We ask that you arrive on time to your appointment. If you are more than **15 minutes** late you may be rescheduled for later the same day, if the schedule permits, or we may have to reschedule your appointment for another day.

Initials_____No Shows: Patients who do not keep their appointments, and who do not call to cancel in a reasonable amount of time, deprive others of the opportunity to see their doctor. Please call us as soon as you know that you will not be able to make your appointment. If, over a period of 6 months, more than **3** appointments are missed without notification, the practice reserves the right to dismiss the patient.

Name of child/ren: _____

Signature of Parent/Guardian or patient if over 18: _____

Please print name:_____ **Date:** _____