PEDIATRIC CARE PATIENT INFORMATION FORM

Patient Last Name _____ First Name _____ Patient Birthdate _____ Sex

Address _____ City _____ State _____ Zip code _____

Preferred Contact Number _____ **Alternate Contact and PhoneNumber (s)** _____ email _____

Name of Responsible Party _____ Relationship _____ *Address of Responsible Party if Different from child _____ City _____ State _____ Zip _____

Mother's Name (Maiden Name) _____ Birthdate _____ Father's Name _____ Birthdate _____

Mother's Employer _____ Work Number _____ Father's Employer _____ Work number _____

Siblings Names and Dates of Birth _____ Emergency Contact and Number _____

Please check 1 or more:

☐ White ☐ Hispanic/Latino ☐ Black or African American ☐American Indian/Native Alaskan ☐ Asian ☐ Other Pacific Islander ☐Other ☐ I prefer not to answer

Primary Language Please check or fill in ☐ English other _____ ☐ I prefer not to answer

INSURANCE INFORMATION: YOU WILL BE RQUIRED TO PRESENT YOUR INSURANCE CARD AT EVERY VISIT

If your insurance requires a primary care MD PLEASE call the insurance to indicate your primary MD. If you are on an HMO you must follow HMO procedures for eligibility, referrals and emergencies. If your insurance requires a referral, please allow at least (1) one week to process proper forms.

Please note the following financial policies:

Payment or co-pay for services rendered is due at the time of service. It is our policy that the parent bringing the child will pay the co-pay at the time of service regardless of who is responsible. All returned checks will be assessed a $25.00 fee in addition to the check amount. If there is a repeated occurrence, then all payments must be made by cash, money order or credit card.

We will bill your insurance carrier provided proper insurance information is given to us on the day of service. We will make every reasonable effort to assist you with your insurance claims; however, it is your responsibility to provide us with the correct information. If the claims are rejected you will be responsible for the balance due. We will make every reasonable effort to work with you on your balance due, if we fail to get a response from you there may be billing fees assessed. If your bill is sent to our collection agency, a recovery fee of up to 30% of the bill due may be added.

In order to provide the highest quality of care to our patients, cancellation of appointments will require 24-hour notification. We reserve the right to charge a fee for any missed appointments without 24-hour notification.

I would like to opt ◯IN ◯OUT eHx *(electronic sharing of medical records)* _____

Signature of Parent /Guardian/Patient

I would like to opt ◯IN ◯OUT ICARE *(Immunization Registry)* _____

Signature of Parent /Guardian/Patient

**** I am over 18 and I consent to the release of information to my parents** _____ **Please sign**

I agree to the above financial policies and to the assignment of Benefits and Release of information. I authorize payment of insurance benefits directly to the physician for professional services rendered. I authorize the release of any medical and other information necessary to process claims and payments.

Signature of Parent /Guardian/Patient _____ Date _____

Who can we thank for referring you? _____

Thank You for choosing Pediatric Care

Please complete both sides

ecw 07/21

Pediatric Care P.C.
27790 W Highway 22, Suite 7
Barrington, Illinois 60010
847 382-7337 telephone
847 382-7377 fax

Notice of Privacy Practices Patient Acknowledgement

Patient Name:_____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect. ..
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health
    - information, and that this practice is not required to agree to a requested restriction
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information. -The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____