Twelve Oaks Pediatrics

PATIENT INFORMATION — PLEASE PRINT

Name of Patient: Date:

Home Address: City: State: Zip:

Daytime Phone: Other Phone: Email:

Date of Birth: Sex: ☐ M ☐ F Parents Names:

Mom's Work #: Cell #: Dad's Work #: Cell #:

Person Financially Responsible for Patient: Relationship:

Emergency Contact: Relationship: Phone:

Whom May We Thank for Referring You:

PRIMARY INSURANCE

Name of Insured: Relationship to Patient:

Address (if different from patient):

Insured's Date of Birth: Insured's Employer: Work #:

Insurance Plan Name:

Policy Number: Group Number:

Copay: Deductible: Type of Plan: ☐ HMO ☐ PPO ☐ Commercial

SECONDARY INSURANCE

Name of Insured: Relationship to Patient:

Address (if different from patient):

Insured's Date of Birth: Insured's Employer: Work #:

Insurance Plan Name:

Policy Number: Group Number:

Copay: Deductible: Type of Plan: ☐ HMO ☐ PPO ☐ Commercial

AUTHORIZATION FOR TREATMENT

I authorize any medical provider at Twelve Oaks Pediatrics to provide medical treatment for myself or my child or _____ (name).

Signature: Relationship to Patient:

ASSIGNMENT OF INSURANCE BENEFITS

I request that payment of authorized insurance benefits be made to me or on my behalf to Twelve Oaks Pediatrics for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the _____ (name of insurance company) and its agents any information needed to determine benefits payable for related services. This authorization is in effect for my lifetime, or until I choose to revoke it.

Signature: Date:

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PATIENT DEMOGRAPHICS QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Account # (office use only): _____

We are asking for your race and ethnicity because some people have higher risks of developing certain diseases. It is also important that we know your preferred spoken language so that you and your health care team can communicate clearly.

We will keep this information confidential (private) and will update it in your medical record. This information will assist us in continuing to provide you with the best health care.

Please fill in the information below. We greatly appreciate your participation.

1. **Race – please mark which best describes you.**
   - ☐ White/Caucasian
   - ☐ Black/African American
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Native Hawaiian
   - ☐ Other Pacific Islander
   - ☐ More than one race
   - ☐ I prefer not to answer

2. **Are you of Hispanic Origin?**
   - ☐ Yes
   - ☐ No
   - ☐ I prefer not to answer

3. **Please indicate your preferred spoken language:** _____
   - ☐ I prefer not to answer

4. **Interpreter Services: Would language interpreter services be helpful to you during your medical visit?**
   - ☐ Yes
   - ☐ No

5. **Email address (please print):** _____

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AUTHORIZATION AND AGREEMENTS OF MEDICAL TREATMENT INSURANCE BENEFITS AND FINANCIAL RESPONSIBILITY

CONSENT FOR EXAMINATION: l understand that medical treatment may be necessary for the patient by Twelve Oaks Pediatrics, or associates or assistants.

l understand the examination will be explained to me and l shall consent to the partial or complete examination. l understand that the examination results will be provided to me with recommendations. The responsibility for any follow-up examinations to check abnormalities found and treated, lies with me and not with my physician. l hereby release my examiner from all responsibility in connection with this examination.

CONSENT FOR TREATMENT: | understand that medical treatment is necessary for the patient by Twelve Oaks Pediatrics or associates or assistants. l hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the physician. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments.

1. Payment is due at the time of service. We accept cash, checks, and credit cards.
2. A schedule of fees for our services is available at the reception desk. Our office will submit claims to your insurance company as a service to you. It is important that you know what your insurance plan covers. Services not covered by your insurance are your responsibility.
3. If your insurance company requires laboratory specimens be sent to a specific lab, it is your responsibility to know the participating lab. Please make us aware of plan requirements.
4. If your insurance is a managed care plan please review your coverage. If you require services that require a referral adequate planning is essential. Referrals must be authorized by your doctor and usually require an office visit. Authorization from managed care plans for your referrals may take one or more weeks. Please be aware that we are often unable to accommodate call in requests for referrals with short notice. Failure to obtain necessary authorizations often lead to out of pocket expense. We are happy to assist you in any way with your managed care plan. However, our experience with these plans has demonstrated that planning and adequate lead time are essential. Your knowledge of your plan regulations and benefits as well as adequate planning will help avoid delays and denied claims.
5. In the case of estranged or divorced parents, the parent accompanying the child to the visit is responsible to pay for services rendered regardless of coverage arrangements. We will gladly furnish you with necessary statements for reimbursement.
6. Your doctor is here to manage your medical care. The physicians are not experts on insurance and cannot be aware of all financial arrangements. Please discuss insurance problems and financial arrangements with the business staff.
7. If you are experiencing financial difficulties, please discuss this with the business office staff. We will gladly work with you to make payment arrangements. Accounts over 90 days past due may be referred to a collection agency.

| have read the above Acknowledgements and Agreements and fully understand the same.

Patient's Name (print) _____

Signature of Patient or Guardian _____ Date _____

Relationship to Patient _____ Witness _____ Date _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form.

_____ _____

Guardian or Patient Signature Date

Documentation of Failure to Obtain Signed Acknowledgement

On _____, _____ presented this Acknowledgement of Receipt of Privacy Practices Form to _____ (the patient). The patient refused to provide a signature when requested.

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ELECTRONIC PRESCRIPTIONS FORM

As a convenience to our patients, we are offering electronic prescriptions and prescription renewals. If you are interested, please complete the following questionnaire.

Please be certain that the information you provide is correct. Please ask if you have any questions about medication allergies.

Date completed: _____

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Phone Number: _____

Patient's Address: _____

Street City State Zip

Medication Allergies and Reactions: _____

Pharmacy Name: _____

Pharmacy City and Cross Streets: _____

If you have other children, you may include them below:

Name	Date of Birth	Medication Allergies/Reactions
_____	_____	_____
_____	_____	_____
_____	_____	_____