Pediatric Partners, P.A.

If children have different addresses, different parents, or a different person carries insurance, please complete a separate form for each.

CHILD 1	CHILD 2	CHILD 3
Last Name:_____	Last Name:_____	Last Name:_____
Middle Initial:_____	Middle Initial:_____	Middle Initial:_____
First Name: _____	First Name: _____	First Name: _____
Date of Birth: _____	Date of Birth: _____	Date of Birth: _____
Sex: M / F	Sex: M / F	Sex: M / F
Language: _____	Language: _____	Language: _____
Ethnicity: Hispanic Non-Hispanic Other	Ethnicity: Hispanic Non-Hispanic Other	Ethnicity: Hispanic Non-Hispanic Other
Race: _____	Race: _____	Race: _____
Primary Physician: (please circle)	Primary Physician: (please circle)	Primary Physician: (please circle)
Carter Mellick Ratliff Stuppy	Carter Mellick Ratliff Stuppy	Carter Mellick Ratliff Stuppy

Primary Address: _____Apt: _____ Primary Phone: (_____)_____

City: _____ State: _____ Zip Code: _____

Patient is living with: (circle one) Both Parents Father Mother Parent and Step Parent Other _____

Are Parents: (circle one) Married Single Divorced Separated Widowed

Who carries insurance? Name: _____ Relationship: _____

DOB: _____ Social Security #:_____

Father

Name: _____

SS# _____-_____-_____ DOB _____

Employer: _____

Occupation: _____

Primary Phone: (____) _____

Work Phone: (____) _____

Mobile Phone: (____) _____

Email: _____

IF DIFFERENT FROM PATIENT

Address: _____ Apt. _____

City: _____State: _____ Zip: _____

Mother

Name: _____

SS# _____-_____-_____ DOB _____

Employer: _____

Occupation: _____

Primary Phone: (____) _____

Work Phone: (____) _____

Mobile Phone: (____) _____

Email: _____

IF DIFFERENT FROM PATIENT

Address: _____Apt. _____

City: _____State: _____ Zip: _____

Appointment Reminders: (please circle one) Father or Mother

Primary Phone:(_____)_____ Email: _____ Text: (_____)_____

EMERGENCY CONTACT INFORMATION

Full Name	Relationship to Patient	Phone Number
		Cell: **Home:** **Work:**

CONSENT FOR EXAMINATION, MEDICAL TREATMENT AND CONDITIONS OF EXAMINATION

I hereby authorize the following people to bring my child(ren) to appointments without a parent or guardian present.
I authorize them to consent to any and all examinations, tests, procedures and treatments deemed necessary by the provider.

The providers may discuss diagnosis or treatments with the authorized person(s) listed below. I realize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in this pediatric practice. (If you are a patient over the age of 18 years old please list below individuals the provider may discuss your diagnosis or treatments with).

Full Name	Relationship to Patient	Phone Number

INFORMATION CONCERNING FILING A CLAIM WITH YOUR INSURANCE COMPANY

If we participate with your primary insurance, Pediatric Partners, P.A. will gladly file a claim for you. We will allow your insurance company up to 45 days from the date of service to pay the claim. If your company fails to fully compensate Pediatric Partners, P.A. within this time frame, any unpaid balance becomes your sole responsibility.

AUTHORIZATION TO FILE INSURANCE CLAIMS, RELEASE MEDICAL INFORMATION, ASSIGNMENT OF BENEFITS

- I authorize Pediatric Partners, P.A. to file insurance claims for services and supplies rendered to and for my/our child(ren).
- I authorize Pediatric Partners, P.A. to release information, including my/our child(ren) medical and billing information, to referring or consulting physcians and to patient's insurance company. The transmission of all information may be done electronically.
- I authorize that payment of all third party benefits otherwise payable to me be made directly to Pediatric Partners, P.A.
- I assign to Pediatric Partners, P.A. all payments for medical services and supplies provided to my dependent child(ren).

I understand that I am financially responsible to Pediatric Partners, P.A. for the above named patient (s). If my insurance company fails to fully compensate Pediatric Partners, P.A. any unpaid balance becomes my sole responsibility. I agree to pay all amounts not covered or paid by a third party payer within 14 days. If I fail to pay within 14 days, Pediatric Partners, P.A. has the right to charge my credit card, debit card or health savings card that I have on file with them. In the event Pediatric Partners, P.A. refers my account to an attorney to collect any monies owed to Pediatric Partners, P.A., Pediatric Partners, P.A. shall be entitled to recover reasonable attorney's fees and costs of litigation.

AGREEMENT AS TO CO-PAYMENTS, NON-COVERED OR NON-PAID SERVICES, AND GUARANTEE OF PAYMENT

I understand that Pediatric Partners, P.A. cannot bill for co-payments. Any co-payments or payments for non-covered services are due at the time medical services are provided. I acknowledge that the above information is correct and that I am responsible for the balance on my account for any services not covered or not paid by my insurance plan.

******I acknowledge that I have received or reviewed a copy of the following:***

1) Policies on Privacy Practices and 2) Office Policies and Procedures. Please initial. _____

All of the above forms may be found at www.pediatricpartnerskc.com.

_____ _____

Parent/Guardian or Patient (if over 18 years) Signature **Date**