Pediatric Partners, P.A.

To be completed by patient's 18 years of age and older.

Personal Information

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth (DOB): _____ SS# _____-_____-_____

Sex: M / F Employer: _____

Language: _____ Occupation: _____

Ethnicity: Hispanic Non-Hispanic Other Cell Phone #: _____

Race: _____ Email: _____

Primary Physician: (please circle)

Carter Mellick Ratliff Stuppy Stanton

Please ask for your portal log-in credentials.

Primary Address: _____Apt: _____

City: _____ State: _____ Zip Code: _____

Who are you living with: (circle one) Self 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: Will be sent via text message

☐ Text: (_____) _____

(PLEASE TURN OVER)

EMERGENCY CONTACT INFORMATION

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

CONSENT FOR EXAMINATION, MEDICAL TREATMENT AND CONDITIONS OF EXAMINATION

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.

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 me.
- I authorize Pediatric Partners, P.A. to release information, including my medical and billing information, to referring or consulting physicians and to my 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 me.

I understand that I am financially responsible to Pediatric Partners, P.A. 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.

_____ _____

Patient Signature **Date**

We/I will take financial responsible for any charges incurred at Pediatric Partners, PA by our/my adult child.

_____ _____

Parent/Guardian Signature **Date**