JC PEDS

PATIENT DEMOGRAPHIC INFORMATION FORM			
First Name:	Middle Name:	Last Name:	Suffix:
Preferred Name:	Date of Birth:	Sex: _____male _____female	
Race: ___American Indian or Alaska Native ___Asian ___Black or African American ___Native Hawaiian or Other Pacific Islander ___White ___Prefers not to answer			
Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___Prefers not to answer		Preferred Language:	
PARENT #1			
First Name:		Last Name:	
Mailing Address:			
Home Phone:	Cell Phone:	Work Phone:	
Email Address:		Date of Birth:	
PARENT #2			
First Name:		Last Name:	
Mailing Address:			
Home Phone:	Cell Phone:	Work Phone:	
Email Address:		Date of Birth:	
INSURANCE INFORMATION			
Insurance Name:		Effective Date:	
Policy Number:		Group Number:	
Subscriber Name:		Subscriber Date of Birth:	
Subscriber Address:			
Employer Name:		Patient Relationship to Subscriber:	
SIBLING			
First Name:	Middle Name:	Last Name:	Suffix:
Preferred Name:	Date of Birth:	Sex: _____male _____female	
Race: ___American Indian or Alaska Native ___Asian ___Black or African American ___Native Hawaiian or Other Pacific Islander ___White ___Prefers not to answer			
Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___Prefers not to answer		Preferred Language:	

Consent To Treat - Minor

I hereby give consent to JC PEDS, LLC to perform any radiology or lab testing, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician, as well as any medical assistant or nurse practitioner on the staff of JC PEDS, LLC to the minor(s) named below. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required. This consent is given to any and all such diagnoses, treatments and hospital care which a licensed physician at JC PEDS, LLC recommends.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Minor #1: Name _____ Date of Birth _____

Minor #2: Name _____ Date of Birth _____

Minor #3: Name _____ Date of Birth _____

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Please specify relationship to minor, circle one:

Parent with legal custody Guardian with legal custody

Consent To Treat - Adult

I hereby give consent to JC PEDS, LLC to perform any radiology or lab testing, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician, as well as any medical assistant or nurse practitioner on the staff of JC PEDS, LLC. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required. This consent is given to any and all such diagnoses, treatments and hospital care which a licensed physician at JC PEDS, LLC recommends.

This authorization will remain in effect until revoked in writing.

Print Patient Name: _____

Patient Signature: _____ Date: _____

Consent to Authorize Medical Care

The following person(s) have my permission to bring _____,
Child's Name

_____, to JC Peds, LLC for medical care and treatment.
Date of Birth

The person(s) listed below can also receive medical advice concerning the above patient in person or over the phone. They will also be able to pick up necessary prescriptions (including controlled substances), x-ray and lab slips. Please note any person picking up forms, prescriptions and/or lab/x-ray slips must be 18 & older and have a valid Driver License with them.

Name _____ Name _____

Relationship _____ Relationship _____

Phone #:_____ Phone#: _____

Name _____ Name _____

Relationship _____ Relationship _____

Phone #:_____ Phone#: _____

By signing below, I acknowledge that I have read and understand the above policy.

_____ _____
Patient Name (please print) Date of Birth

_____
Parent/Guardian Signature:

Relationship to Patient (please check): ____Parent ____Self ____Other: _____

Vaccine Policy Statement

- We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We firmly believe in the safety of our vaccines
- We firmly believe that all children and young adults should receive all the recommended vaccines according to the schedule published by the Center for Disease Control and Prevention and the American Academy of Pediatrics.
- We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities.
- We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, **should you have doubts, please discuss these with your healthcare provider prior to your visit. Please be advised that delaying or "breaking up vaccines' ' to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers. Finally, if you should absolutely refuse to vaccinate your child despite our efforts (at his/her first visit) we will not be able to care for your child.**

As medical professionals, we feel strongly that vaccinating your children on schedule with current available vaccines is absolutely the right thing to do for all children and young adults. Thank You for your time in reading this policy and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

By signing below, I acknowledge that I have read and understand the above policy.

_____ _____

Patient Name (please print) Date of Birth

_____

Parent/Guardian Signature:

Relationship to Patient (please check): ____Parent ____Self ____Other: _____

ASSIGNMENT OF BENEFITS FORM

All professional services rendered are charged to the patient and are due at the time of service, unless insurance coverage is verified and JC PEDS, LLC is a participating provider. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to JC PEDS, LLC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize JC PEDS, LLC to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims.

This order will remain in effect until revoked by me in writing.

I have requested medical services from JC PEDS. LLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

By signing below, I acknowledge that I have read and understand the above policy.

_____ _____
Patient Name (please print) Date of Birth

_____
Parent/Guardian Signature:

Relationship to Patient (please check): ____Parent ____Self ____Other: _____

Financial Policy

PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE RENDERED

- A valid and current insurance care must be provided at the time of service and any time there is a change to the insurance.
- We submit claims to insurers and ask that you promptly pay applicable co-pays, co-insurances, or deductibles at the time of the visit. If you participate in a deductible plan and have not yet met your deductible in full, a $50 payment will be collected on any non-preventative services.
- The responsibility for payment of services rendered to any minor children rests with the parent or guardian who seeks treatment. Separated/Divorced parents; if the divorce decree requires the other parent to pay all or part of medical costs, it is your responsibility to seek reimbursement from them. JC Peds can not act as a mediator in collecting payment.
- Your insurance policy is a contract between you, your employer(s), and your insurance company. Insurance policies have different benefits and we cannot know the specific details for each policy. It is your responsibility to understand your plan benefits and coverage for services rendered. Please check with your insurance carrier to confirm your specific policy, co-pays, deductibles and exclusions.
- Self pay patients will receive a 25% discount if the bill is paid in full at the time of service.

NOTIFICATIONS OF CHANGES

- You are responsible for informing our office of any insurances, address, or contact information changes. If your insurance is found to be inactive at the time of service, self-pay charges will be applied to your accounts.

NEWBORN CHARGES

- Your infant will not be automatically enrolled into your insurance until you notify them of birth. As a courtesy to new parents, we allow up to 30 days for you to notify your insurance carrier. After this time, you will be billed for balances due.
- Recheck appointments are assessed the same co-pay as other office visits.
- Most insurance carriers will cover 7 wellness visits during your child's first year of life. It is your responsibility to review your policy. We cannot treat your child based on insurance coverage alone.

WELLNESS VISITS

- All wellness visits should be scheduled one year and one day from the last visit.
- Some health and development screenings, such as ASQ Development Questionnnaire, PHQ9 Patient Health Questionnaire, hearing and vision screenings, immunizations may not be covered by your insurance plan. It will be your financial responsibility should your insurance policy consider these services as a non covered benefit.
- During a wellness visit if any additional concerns or conditions arise, there may be an additional charge that may require a co-payment, deductible, or co-insurance.

METHODS OF PAYMENTS

- We accept cash, personal checks, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS and debit cards. There is a $25.00 service charge for returned checks.
- Any unpaid amounts sent to a collection agency are subject to an additional 25% collection fee.

MISSED APPOINTMENTS

- Missed appointments represent a cost to JC Peds, and to other patients who could have been treated in the time set aside for your visit. Cancellations are requested within 24 hours of appointment. Excessive missed appointments may result in a discharge from our practice.

LATE APPOINTMENTS

- JC PEDS understands that situations can arise that may prevent you from arriving at your appointment on time. If you are going to arrive late for your scheduled appointment please call our office. In addition, if you arrive more than 10 minutes late for your scheduled appointment you may be asked to reschedule.

HIPAA Acknowledgement

I have read, acknowledge and accept the HIPAA Notice of Privacy Practices for JC PEDS, LLC given to me.

_____ _____

Parent/Guardian Signature Today's Date.