SUMMIT PEDIATRICS

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p: (775) 624-6350 f: (775) 624-6353
www.summitpediatricsreno.com

PATIENT INFORMATION FORM

Patient's Last Name | First Name | MI | Male/Female

Street Address | City | State | Zip

Home Phone | Parent's Cell | Date of Birth | Age

Mother's Last Name | First Name | MI

Street Address | City | State | Zip

Home Phone | Work Phone | Employer | Date of Birth

Marital Status | Social Security Number | Driver's License Number

Father's Last Name | First Name | MI

Street Address | City | State | Zip

Home Phone | Work Phone | Employer | Date of Birth

Marital Status | Social Security Number | Driver's License Number

Sibling Name | Date of Birth | Age

Sibling Name | Date of Birth | Age

Sibling Name | Date of Birth | Age

Emergency Contact (OTHER THAN PARENT) | **Phone** | **Relationship to Patient**

Primary Insured's Name | Relationship to Patient | Social Security Number

Primary Insurance Carrier | Policy # | Group #

Insurance Claims Address | City | State | Zip

Employer's Address | City | State | Zip

Secondary Insured's Name | Relationship to Patient | Social Security Number

Secondary Insurance Carrier | Policy # | Group #

Insurance Claims Address | City | State | Zip

Employer's Address | City | State | Zip

YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, REGARDLESS OF INSURANCE!

1. You agree to pay all deductibles, insurance co-pays and co-insurance at the time of check-in and prior to services being rendered.
2. If Summit Pediatrics cannot verify your insurance at the time of visit, or if you do not bring current proof of insurance to each visit, you agree to pay charges in full before the patient can be seen.
3. You will receive a statement showing in detail charges incurred during the statement period and the amount due. Any uncollected fees are payable within 15 days of receiving the statement. You are responsible for complete payment of any charges that you incur whether covered by your insurance or not covered by your insurance. If your account becomes delinquent and referred to a collection agency, you will be responsible for the costs of collection and/or legal fees. All accounts that are 90 days past due will automatically be assigned to a collection agency, regardless of insurance coverage. Accounts assigned to collections will include a 30% collections and processing fee.
4. If you miss an appointment without a 24-hour prior notification to this office, you agree to pay a $35.00 charge.
5. You agree to pay a $25.00 charge for any returned checks.
6. While your appointment may be for a specific time, no express or implied guarantee is made that a nurse or physician will see you at that exact time. Summit Pediatrics makes every effort to see patients in a timely fashion, subject to patient volume and emergencies beyond our control. You agree not to hold Summit Pediatrics responsible in any manner for time spent waiting to be seen.
7. If your insurance has not paid this office within 90 days, you agree to pay all charges which have been incurred by you or your dependents at the time of visit.
8. As the child's parent, you understand that it is your responsibility to make and attend all follow-up visits ordered by the doctor. You understand that the doctor would not order a follow-up visit if it was not important. You also understand that Summit Pediatrics cannot call you and remind you that you need to make a follow-up appointment. Therefore, it is your responsibility to make the appointment and you accept all responsibility if you should fail to schedule or attend a follow-up visit.
9. As the child's parent, you understand it's your responsibility to make and attend appointments when referred to a specialist. You accept all responsibility if you fail to schedule or attend specialist appointments.

(a) _____ (b) _____ _____

Please Print Name (a) & Sign (b) to indicate you understand and accept our policies **Date**

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Patient Name: _____ DOB: _____

In an effort to provide our patients with the best possible healthcare it may be necessary for your physician to request specific tests or services. The decision may be based on current symptoms, concerns or simply to evaluate your child's health as a preventative or routine exam according to age, past personal or family history of illness.

If such services are done, your insurance company may deny payment or apply payment toward your out-of-pocket deductible. We will bill your health plan for all services provided to allow your plan to determine payable benefits. The most common services denied include (but are not limited to):

1. Routine physical exams 2. Vaccines 3. Emergency services same day fee 4. After Hours Fee
5. Cerumen (Wax) removal from ear 6. ADHD follow up exams 7. Vision and Hearing Screening
8. In-office lab tests (such as Strep, RSV, flu and glucose) 9. Wart removal 10. Granuloma cauterization

By signing this waiver, you understand the information above and understand and agree that in the event of non-payment or application to deductible you will be personally and fully responsible for payment. As a condition of servicing the health care needs of the above referenced patient, I (the parent, legal guardian, subscriber) hereby attest that the patient is an "Eligible" member of the health plan listed below as of this date of service. I further hereby attest and agree that, should the patient be determined "Ineligible" for the services rendered by this Provider, I shall comply with the demands of payment to the Provider.

Subscriber Name: _____ ID#: _____

I hereby confirm that the above information is true and correct. I also agree to pay the Provider for services rendered if the Health Plan determines that I am not eligible for services rendered at this date of service.

Signature: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Summit Pediatrics reserves the right to modify the privacy practices outlined in the notice.

I have received / read a copy of the Notice of Privacy Practices for Summit Pediatrics.

_____ _____ _____
Patient Name (Please Print) Patient Signature Date

_____ _____
Signature of Patient Representative *(required if patient is a minor or an adult unable to sign this form)* Relationship to Patient

ACKNOWLEDGMENT OF RECEIPT OF OFFICE POLICIES

_____ _____ _____
Patient Name DOB Date

I acknowledge I have received and read the Office Policies for Summit Pediatrics. **Please initial each POLICY below**:

____ Appointment ____ No Show ____Pharmacy ____Lab & X Rays ____Medical Records ____Payment

_____ _____
Patient/Guardian Name (Please Print) Patient/Guardian Signature

If Guardian, relationship to patient: _____