Columbus Pediatric Associates

Patient Information **Date:** _____

Name:_____ ____/____/____ ☐ ☐ Male ☐ ☐ Female
Last First Middle Date of Birth

Name:_____ ____/____/____ ☐ ☐ Male ☐ ☐ Female
Last First Middle Date of Birth

Name:_____ ____/____/____ ☐ ☐ Male ☐ ☐ Female
Last First Middle Date of Birth

Name:_____ ____/____/____ ☐ ☐ Male ☐ ☐ Female
Last First Middle Date of Birth

Address: _____ Home Phone: _____

City: _____ Preferred Pharmacy: _____

State: _____ Zip: _____ Location: _____

Parent/Legal Guardian Information

Name: _____
Last First Middle

Address: _____ Cell Phone: _____

City: _____ Email: _____ @ _____

State: _____ ZIP: _____ Birth Date: _____ / _____ / _____

Relationship to child: _____ Social Security # ____ / ___/ _____

Employer: _____ Work Phone: _____- _____- _____

Spouse/Other Legal Guardian Information

Name:_____
Last First Middle

Address: _____ Cell Phone: _____

City: _____ Email: _____ @ _____

Relationship to child: _____ Social Security # ____ / ____/ _____

Employer: _____ Work Phone: _____

Signature Parent/Guardian _____ Date _____

PATIENT ACKNOWLEDGEMENT OF UNDERSTANDING OF COLUMBUS PEDIATRIC ASSOCIATES NOTICE FO PRIVACY PRACTICES

In 1996, Federal law was passed regarding the Privacy Regulations created from the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This was created as a direct result of the electronic filing and exchange of health information while protecting a patient's privacy.

Parent's Name: _____ SSN: _____

Patient's Name:_____ DOB:_____

Patient's Name:_____ DOB:_____

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Patient's Name:_____ DOB:_____

I understand the patient's health information is private and confidential. I understand that **Columbus Pediatric Associates**, works diligently to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that **Columbus Pediatric Associates**, may use and disclose the patient's personal health information to help to provide health care to the patient, to handle billing and payment, and to take care of other health care operations. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual.

Columbus Pediatric Associates, has a detailed document called "Notice of Privacy Practices". This document contains more detailed information about the policies and practices protecting the patient's privacy. I understand I have the right to read the "Notice" before signing this acknowledgement. I understand **Columbus Pediatric Associates** will change and amend the Notice as it deems necessary without individual notification. I understand the most recent amended notice will be available for review for parents/guarantors.

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include but are not limited to access to my medical records, restrictions on certain uses, receiving an accounting of disclosures as required by law, and requesting communication be by specified methods of communications or alternative action.

Columbus Pediatric Associates, has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written authorizations, reasonable time frames for requesting information, charges for non-routine needs, etc. I will assist **Columbus Pediatric Associates**, by following these procedures if I chose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature indicates I have been given the chance to review a current copy of **Columbus Pediatric Associates**, "Notice of Privacy Practices".

_____

Signature Relationship to Patient Date Time

Columbus Pediatric Associates

We are committed to providing your child with the best possible medical care. The following information is provided to avoid any misunderstanding or disagreement for professional services.

Consent to Treat

We follow the guidelines of the American Academy of Pediatrics in the treatment recommended for your child. I authorize any physician of clinical staff member of **Columbus Pediatric Associates** to provide medical treatment for my child/children. This includes hospitalizations, injections, anesthesia, immunizations, referrals and emergency treatment. **Immunization will be administered as recommended** by the American Academy of Pediatrics and the Centers for Disease Control (CDC). If you do not wish for your child to receive immunizations, you must discuss this with the physician.

Financial Policy

We will file insurance as a COURTESY; however, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR CHILD'S CHARGES.

1. Our office participates with a variety of insurance plans.
   It is your responsibility to:
   - **Bring your insurance card and photo I.D. at every visit.**
   - **Pay your Co-Payment and /or any deductibles at each visit.** Payment can be made by cash, check or credit card. We accept VISA and MasterCard. We do not bill for Co-payments.
   - **Pay in full for any medical care of services that are not covered by your insurance plan.**
2. If your child has insurance that we do not participate with, or your child does not have insurance, payment in full is expected at the time of service.
3. Your insurance plan may require you to choose a PCP (Primary Care Provider). You will need to choose a physician from our practice. If your insurance card lists another physician's name, we will see your child, but you will be required to pay at the time of service until the PCP has been changed to one of our physicians.
4. **You are financially responsible for all charges incurred in your child's care and treatment if not covered by the insurance plan. Not all services may be covered by your plan.**
5. If you have questions about your insurance, we are happy to help. However, specific coverage issues should be directed to your insurance company member services department. The telephone number is located on your insurance card.
6. Failure to meet your financial obligations with this office could lead to dismissal from the practice. Any outstanding balances may be sent to an outside collection agency.
7. To protect your child's records, we ask you to provide our office with a driver's license or other picture identification. Annually, or as changes occur, we will ask you to update and sign our Registration Form. We will scan your insurance card, ID, and Registration form into your child's electronic medical chart.
8. In cases of divorce and /or separation, the legal guardian will be held responsible for paying any balance originating from that visit. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person, you will be held responsible for the balance on your child's account.

Signature of Understanding and Consent: I have read, understand and consent to the above policies of **Columbus Pediatric Associates.**

Childs Name: _____ Date of Birth: _____
Childs Name: _____ Date of Birth: _____
Childs Name: _____ Date of Birth: _____
Childs Name: _____ Date of Birth: _____

Signature of Parent/Guardian _____ **Date** _____