Parker Pediatrics & Adolescents, P.C.
Patient Information - Family Form

How did you hear about us?: Friend Referral ☐ Insurance Network ☐ Parker Days ☐ Internet ☐ OBGYN ☐ Other ☐

As part of our commitment to provide our patients with timely information, we do sent out regular e-mails to keep our families advised of important information, infection reports, changes to office routine, or other information that could be helpful to patients and their families.
Please be sure to sign up by adding your e-mail to the second page of our Patient Information form, visiting our website E-mail Page to sign up, or use your smart phone to scan the QR readers posted around the office to complete the sign up process.

PATIENT DATA

The "Family Form" can be used if all children in the family have the same information. If not, i.e. foster care, blended family, or separation/divorce, please complete individual forms for each child.
FOR THE FAMILY FORM - PLEASE LIST EACH CHILD IN FAMILY BELOW

Office Use	Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yy)	Gender	Child Resides With
☐				/ /	☐ Male ☐ Female	☐ Mother ☐ Father ☐ Both
☐				/ /	☐ Male ☐ Female	☐ Mother ☐ Father ☐ Both
☐				/ /	☐ Male ☐ Female	☐ Mother ☐ Father ☐ Both
☐				/ /	☐ Male ☐ Female	☐ Mother ☐ Father ☐ Both

Financially Responsible Party _____

Mailing/Billing Address _____

City State Zip

TELEPHONE NUMBERS

- **Primary phone (#1) should be the cell phone number where you wish to receive texts for appointment reminders.**
- **Please list other phone numbers in order to be called. Work numbers should not be used as primary contact numbers, unless a cell number.**

1	■ **Cell Only**	☐ Mother ☐ Father	☐ Other: _____
2	☐ Home ☐ Cell	☐ Mother ☐ Father	☐ Other: _____
3	☐ Home ☐ Cell ☐ Work	☐ Mother ☐ Father	☐ Other: _____
4	☐ Home ☐ Cell ☐ Work	☐ Mother ☐ Father	☐ Other: _____

PARENT / GUARDIAN INFORMATION

Mother's Name _____ DOB / /

☐ Single ☐ Married ☐ Divorced ☐ Widowed **Relationship to Child:** Parent ☐ Step Parent ☐ Foster/Guardian ☐

Physical Address *(if different from above)* _____

E-Mail Address _____

Employer/ Occupation _____ Phone Number - -

Father's Name _____ DOB / /

☐ Single ☐ Married ☐ Divorced ☐ Widowed **Relationship to Child:** Parent ☐ Step Parent ☐ Foster/Guardian ☐

Physical Address *(if different from above)* _____

E-Mail Address _____

Employer/ Occupation _____ Phone Number - -

Custodial parent, if applicable _____

Step parent's names, if applicable

MISCELLANEOUS DATA

Emergency Contact (other than above) _____ Phone - -

Former Pediatrician (if applicable) _____ Referred by _____

Parent/Guardian Signature _____ Date _____

Please List All Names on Top of Form / Read and Initial All Boxes / Sign and Date at Bottom

Patient Name(s): Date(s) of Birth:	

INSURANCE DATA

☐ **No change to Insurance (for existing patients only)**

Effective Date ____ ____ / ____ ____ / ____ ____

Insurance Company Name

Aetna ☐ BCBS ☐ Cigna ☐ Colo Access ☐ Cofinity ☐ Colo Health Network ☐ Humana ☐ Medicaid ☐ Rocky Mtn ☐ United ☐ Other ☐

Name of Insurance, if not listed above:

Insurance Claim Address _____

City _____ State _____ Zip _____

Insurance Phone Number ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Policy Holder Name (Guarantor)

Policy Holder DOB ____ ____ / ____ ____ / ____ ____

Insurance ID # ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Group # ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

VACCINE POLICY / CONSENT FOR PAYMENT / ASSIGNMENT OF INSURANCE BENEFITS / PRIVACY POLICY

VACCINE POLICY

☐ Initial

I understand that Parker Pediatrics & Adolescents **only** accepts patients into the practice who agree to meet the minimum recommended vaccination schedule/timetable and that any child(ren) who may be behind on vaccines will be brought current as soon as possible.

CONSENT FOR PAYMENT

☐ Initial

I understand that I am financially responsible for all professional charges that my child(ren) may incur. Payment for these services is due at the time of service. Patients covered under a contracted insurance plan are required to pay any co-payment, deductible, or co-insurance at the time of service or promptly when billed.

I understand that **Insurance/Medicaid Cards should be presented at EVERY VISIT**.

☐ Initial

I hereby authorize direct payment of surgical/medical benefits to **Parker Pediatrics and Adolescents, P.C.**, for service rendered. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize **Parker Pediatrics and Adolescents, P.C.** to release any medical or incidental information that may be necessary for either medical care or processing applications for financial benefit.

☐ Initial

Divorce has no bearing on the responsibility for medical care as it affects third parties. **WHOEVER BRINGS THE CHILD IS EXPECTED TO PAY THE CHARGES DUE FOR THE SERVICE RENDERED THAT DAY.** Parker Pediatrics & Adolescents does not participate in payment disputes between parents.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

☐ Initial

I have received, or have been given the opportunity to receive, a copy of the **HIPAA Notice of Privacy Practices for Parker Pediatrics & Adolescents, P.C.**

E-MAIL PERMISSION

I **DO** wish to be included in the Parker Pediatrics e-mail list to receive occasional brief announcements and timely information. (***Strongly recommended in order to receive flu clinic dates, local epidemics / infection reports, office policy changes, and the link to our newsletter.***)

☐ I presently receive Parker Pediatrics emails

☐ Please add me to the Parker Pediatrics email distribution list. Preferred email address(es) below:

1 _____

2 _____

- I understand that I may opt out at any time.
- I understand that this information is NOT shared with third parties and is for the exclusive use of Parker Pediatrics.

☐ I **DO NOT** wish to be included in the Parker Pediatrics e-mail list.

The above information is current and correct.

Parent/Guardian Signature _____ Date _____

PARKER PEDIATRICS & ADOLESCENTS, P.C.

NEW PATIENT MEDICAL INFORMATION SHEET

(Please Print)

Newborn History

Name:	DOB:	Phone:
☐ Parker Adventist ☐ Sky Ridge ☐ Other:		OB:
# of Pregnancies:	# of Live Births:	Length of Pregnancy:
Pregnancy Problems:		
Delivery: ☐ Vaginal ☐ C-Section (Reason):		
Delivery Problems:		
Apgars: /	Mother's Blood Type:	Baby's Blood Type: Coombs:
Nursery Problems:		

Birth Weight: lb oz	Length:	Head Size:	Discharge Date:	Discharge Weight:	Feeding: ☐ Breast ☐ Bottle

Family Health History

	Age	Health Problems	Smoker	Height	Weight
Father (of Patient)			☐		
Grandfather			☐		
Grandmother			☐		
Mother (of Patient)			☐		
Grandfather			☐		
Grandmother			☐		
Sibling(s) (of Patient)			☐		
			☐		
			☐		

Diseases or Problems in Family or Close Relatives, Including Infant Deaths and Birth Defects: ☐ None

Patient's Medical History – Attach Additional Documentation As Needed

Hospitalizations/surgeries (type, where, when) ☐ None

Injuries: ☐ None

Major Illnesses or Chronic Problems: ☐ None

Allergies: ☐ None

Daily Medications: ☐ None

Development: ☐ Normal ☐ Delayed / What Areas:

Immunization Dates: ☐ Record from previous medical provider attached

DaPT/DPT/DT		Polio		Hib		MMR	
Hep B		Rotavirus		Hep A		Tdap	
Pneumococcal (Prevnar)				Chickenpox (Varivax)			
Gardasil				Meningococcal			

Systems Review

(Answer "Yes" if these are chronic or ongoing problems)

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Headaches	☐	☐	Vomiting	☐	☐	Birthmarks	☐	☐	Bruising	☐	☐	Dizzy Spells	☐	☐
Diarrhea	☐	☐	Fainting Spells	☐	☐	Constipation	☐	☐	Nosebleeds	☐	☐	Seizures	☐	☐
Stomach Pain	☐	☐	Hyperactive	☐	☐	Weakness/Paralysis	☐	☐	Painful Urination	☐	☐	Speech Problems	☐	☐
Visual Problems	☐	☐	Menstrual Cramps	☐	☐	Behavior Problems	☐	☐	Hearing Problems	☐	☐	Bedwetting	☐	☐
Learning Problems	☐	☐	Ear Infections	☐	☐	Swollen Joints	☐	☐	Chest Pain	☐	☐	Limp	☐	☐
Coughing	☐	☐	Acne	☐	☐	Shortness of Breath	☐	☐	Dental Problems	☐	☐	Attention Disorder	☐	☐
Strep Throats	☐	☐	High Blood Pressure	☐	☐	Appetite Problems	☐	☐	Heart Murmur	☐	☐	Other	☐	☐

Parker Pediatrics and Adolescents, P.C.
Financial Policy

Parker Pediatrics and Adolescents, P.C. (PPA) wants to be sure that you understand our responsibility to you and your insurance company as well as your financial responsibility to us. Please read this carefully, ask further questions if needed, then sign.

We participate with the following insurance plans: **Aetna, Anthem/Blue Cross Blue Shield, Cigna, Colorado Children's Health Plan (CHP), Cofinity, Colorado Health Neighborhood, Humana, Medicaid, Rocky Mountain, and United Healthcare**. If you are not a member of one of our contracted plans, we will be happy to see you under a fee-for service agreement. Payment is expected to be paid at the time of service and you will receive a copy of the fee slip to submit to your plan. We offer a discount for anyone who pays for their visit in full at the time of service.

It is your responsibility to understand your particular plan as well as any health savings plans you may have in effect. According to your insurance plan, you are responsible for any copays, deductibles, coinsurance or non-covered services. Copays are due at the time of your visit.

Credit Card on File

This is the most convenient, cost effective and green method for paying any balances due on your account. You can be assured that your credit card information will be safe and secure in the encrypted merchant services vault with Authorize.Net. Once the information has been received, it will be secured in a lock box until it is ready to be entered into our credit card system. We will then shred the information and from that point forward, will only have access to the last 4 digits. We accept Visa, Mastercard, American Express and Discover.

Your insurance company will be billed and when we receive payment from them, any balance due by you will be applied to your credit card which may not be for another 30 days as most insurance claims take 2 to 3 weeks to process. PPA will only utilize your credit card on file for balances due on your account. If you choose not to give us a credit card to keep on file, then it is expected that you will pay your statement promptly upon receipt. We offer online bill pay as well.

The maximum amount that would automatically be charged to your credit card is $300. For accounts with balances over $300, we will charge the first $300 and then you will be notified of the balance for permission to charge your credit card with the balance or to make payment arrangements.

Please be assured that if there are financial difficulties which preclude you from settling your account, we are more than happy to work with you but you must communicate this to us and make a plan with our Business Office. Also be aware, that unless you have a credit card on file, the adult who accompanies the patient or the unaccompanied adolescent will be responsible for copayments.

Cancellation Policy

Well visit/annual exam and asthma appointments require a 24 hour cancellation notice and all psychology appointments require a 48 hour notice. Late cancellation/no show fees respectively range from $65.00 to $85.00. Under certain circumstances, patients may be discharged from our practice in lieu of this fee.

Collections

If there are financial difficulties, we will work with you to allow uninterrupted care for your child(ren). If, however, you fail to respond to your financial obligation either by payment or arrangements with our Business Office, we will need to enforce our collection policy. This could involve your account being turned over to our collection agency, collection fees assessed and dismissal from our practice.

Name: _____ Date: _____

Name of Child/Children: _____

Signature: _____

Parker Pediatrics and Adolescents, P.C.
Balance Billing

For your convenience, we now offer secure credit card storage. What this means for you is that we will bill your insurance company and once the claim has been processed, we will automatically charge your credit card on file for any balance due. You can be assured that your credit card information will be safe and secure and only be used for balances due on your account.

Once the information has been received, it will be secured in a lock box until it is ready to be entered into our encrypted merchant services vault with Authorize.Net. We will then shred the information and from that point forward, will only have access to the last 4 digits.

The maximum amount that would automatically be charged to your credit card is $300. For accounts with balances over $300, we will charge the first $300 and then you will be notified of the balance for permission to charge your credit card with the balance or to make payment arrangements.

Please complete this form. If you would like an email receipt of the transaction, please update your email address on the form as well.

*****COPAYS ARE STILL DUE AT TIME OF SERVICE*****

Date:_____

Name of Child/Children:_____

_____

Parent's Name (Please Print):_____

Cardholder's Name and Signature:_____

_____

Cardholder's Address:_____

Email (for receipt):_____

Card #:_____

Expiration Date:_____ Sec. Code:_____

IF YOU HAVE QUESTIONS, PLEASE CALL THE BILLING DEPARTMENT AT (303) 841-2905 EXT. 128