



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

How did you hear about us:

☐ Friend Referral ☐ Insurance Network ☐ Community Event ☐ Internet ☐ OBGYN ☐ Other: *Please specify*

- As part of our commitment to provide our patients with timely information, we do send 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 or visiting our website E-mail Page to submit a sign up request

PATIENT DATA – FULL LEGAL NAME

- The "Family Form" can be used if all children in the family have the same information. PLEASE LIST EACH CHILD IN FAMILY BELOW
- If foster care, blended family, or separation/divorce, please complete individual forms for each child.
- If you are a patient 18 or older – List ONLY yourself and your contact information.

OFC USE	Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yy)				Gender	Child Resides With
<input type="checkbox"/>								<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both
<input type="checkbox"/>								<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both
<input type="checkbox"/>								<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both
<input type="checkbox"/>								<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both

TELEPHONE NUMBERS

- Primary phone (#1) is the one to be used for messages and reminder calls
- Please list phone numbers in order to be called.

1									<input checked="" type="checkbox"/> Cell Only	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Patient (18 Yrs and Older) <input type="checkbox"/> Other
2									<input type="checkbox"/> Cell <input type="checkbox"/> Home	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Other:
3									<input type="checkbox"/> Cell <input type="checkbox"/> Home	<input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Other:

BILLING ADDRESS & FINANCIAL INFORMATION

Name of Financially Responsible Person (1)
Bills mailed to this person.

Billing Address _____ Apt / Unit # _____

Update to Existing ☐ _____

City _____ State _____ Zip _____

PARENT / GUARDIAN INFORMATION – FULL LEGAL NAME

Mother's Name _____ Last Name _____ First Name _____ MI _____ DOB _____

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

Physical Address (if different from above) _____

E-Mail Address _____

Employer / Occupation _____

Father's Name _____ Last Name _____ First Name _____ MI _____ DOB _____

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

Physical Address (if different from above) _____

E-Mail Address _____

Employer / Occupation _____

Custodial parent, if applicable: _____

Stepparent's names, if applicable: _____

** Complete Care Authorization If Needed*

MISCELLANEOUS

Emergency Contact (other than above) _____ Phone _____

Former Pediatrician (if applicable) _____ Referred by _____

Parent / Guardian / Patient Signature _____ Date _____

Printed Name of Signer _____

(1) If parents are not married, financially responsible party must sign this form to accept responsibility.

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

INSURANCE DATA

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

Effective Date			/			/						
Insurance Company Name	Aetna <input type="checkbox"/>	BCBS <input type="checkbox"/>	Bright Health <input type="checkbox"/>	Cigna <input type="checkbox"/>	CHP <input type="checkbox"/>	Cofinity <input type="checkbox"/>	Humana <input type="checkbox"/>	Medicaid <input type="checkbox"/>	Tricare <input type="checkbox"/>	United <input type="checkbox"/>	UMR <input type="checkbox"/>	Other <input type="checkbox"/>
Name of Insurance, if not listed above:												
Insurance Claim Address												
City State Zip												
Insurance Phone Number				-								
Policy Holder Name												
Relationship	<input type="checkbox"/> Parent <input type="checkbox"/> Step-Parent						Policy Holder		DOB			
Address – If Different from Patient / Parent												
Insurance ID #												
Group #												

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

☐ Initial 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 / COMMUNICATION CONSENT

☐ 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.**

☐ Initial I give "consent" to Parker Pediatrics and Adolescents to communicate with me regarding my child's health via text messaging.

E-MAIL PERMISSION

☐ I presently receive Parker Pediatrics emails

☐ I **DO** wish to be included in the Parker Pediatrics e-mail distribution 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 quarterly electronic newsletter.)**

Please use the following as my preferred email address:
*

I understand that I may opt out at any time, 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/Patient Signature _____ Date _____

Newborn History

Name:			DOB:			Phone:		
<input type="checkbox"/> Parker Adventist <input type="checkbox"/> Sky Ridge <input type="checkbox"/> Other:			OB:					
# of Pregnancies:			# of Live Births:			Length of Pregnancy:		
Pregnancy Problems:								
Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> 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: <input type="checkbox"/> Breast <input type="checkbox"/> Bottle

Family Health History

	Age	Health Problems	Smoker	Height	Weight
Father (of Patient)			<input type="checkbox"/>		
Grandfather			<input type="checkbox"/>		
Grandmother			<input type="checkbox"/>		
Mother (of Patient)			<input type="checkbox"/>		
Grandfather			<input type="checkbox"/>		
Grandmother			<input type="checkbox"/>		
Sibling(s) (of Patient)			<input type="checkbox"/>		
			<input type="checkbox"/>		
			<input type="checkbox"/>		

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)	<input type="checkbox"/> None
Injuries:	<input type="checkbox"/> None
Major Illnesses or Chronic Problems:	<input type="checkbox"/> None
Allergies:	<input type="checkbox"/> None
Daily Medications:	<input type="checkbox"/> None
Development:	<input type="checkbox"/> Normal <input type="checkbox"/> Delayed / What Areas:
Immunizations:	Attach record from previous provider / state registry. Please bring to first office visit.

Systems Review

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

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

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 \$200. For accounts with balances over \$200, we will charge the first \$200 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 &
ADOLESCENTS, P.C.**

Serving the Parker community since 1982

10371 Parkglenn Way, Suite 100
Parker, Colorado 80138
Telephone: 303-841-2905
Fax: 303-841-3052 / fax@parkerpediatrics.com

Website: www.parkerpediatrics.com

**DO NOT RETURN THIS FORM TO PARKER PEDIATRICS,
IT NEEDS TO GO TO THE PREVIOUS PROVIDER**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Former Physician:			
Name of Physician/Practice			
Mailing Address			
	Street Address		
	City	State	Zip
Email			
Telephone		Fax	
<p>I have transferred my child(ren)'s medical care to the practice below and hereby request that my child(ren)'s medical records be sent to:</p> <p style="text-align: center;">Parker Pediatrics & Adolescents, P.C. 10371 Parkglenn Way, Suite 100 Parker, CO 80138 Fax: 303-841-3052 fax@parkerpediatrics.com</p> <p><input checked="" type="checkbox"/> Please include ALL records related to patient care at your facility, including but not limited to immunizations, office visits, labs, consults, hospital/ER.</p>			
Effective Date of Release			
Patient Name		Date of Birth	
If you require a different form in order to transfer these records, please send to:			
Patient's Present Address			

I understand that the information to be released may include the following conditions, if present: drug or alcohol abuse, psychological or psychiatric conditions, HIV or AIDS testing or diagnosis. I wish to exclude the following records from being released:

This is a one-time authorization and will expire in 60 days. During this period, this release may be revoked by written notice.

Parent's Signature		Date	
Printed Name			