



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



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.

OFFICE U S E	Last Name	First Name	Middle Initial	Date of Birth						Gender	Child Resides With
				M	M	D	D	Y	Y	<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"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Decline	
										<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both
										<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Decline	
										<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both
										<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Decline	
										<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both
										<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Decline	

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. MUST sign form.

Billing Address _____ Apt / Unit # _____
Update to Existing ☐

City _____ State _____ Zip _____

PARENT / GUARDIAN INFORMATION – FULL LEGAL NAME

Contact _____ DOB _____
Last Name First Name MI M M D D Y Y Y

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

Physical Address (if different from above) _____

E-Mail Address _____
Employer / Occupation _____

Contact _____ DOB _____
Last Name First Name MI M M D D Y Y Y

☐ Single ☐ Married ☐ Divorced ☐ Widowed Relationship to Child: ☐ Mother ☐ Father ☐ 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, or are divorced, the 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

<input type="checkbox"/>	I understand that Parker Pediatrics & Adolescents strongly recommends patients 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.
Initial	

CONSENT FOR PAYMENT

<input type="checkbox"/>	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	
<input type="checkbox"/>	I understand that Insurance/Medicaid Cards should be presented at EVERY VISIT.
Initial	
<input type="checkbox"/>	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	
<input type="checkbox"/>	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.
Initial	

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES / COMMUNICATION CONSENT

<input type="checkbox"/>	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	
<input type="checkbox"/>	I give "consent" to Parker Pediatrics and Adolescents to communicate with me regarding my child's health via text messaging.
Initial	

E-MAIL PERMISSION

<input type="checkbox"/>	I presently receive Parker Pediatrics emails
<input type="checkbox"/>	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.	
<input type="checkbox"/>	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

Child Full Legal Name									
Last		First		Middle		DOB		Phone	
<input type="checkbox"/> Advent Health Parker		<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:		RSV No <input type="checkbox"/> Yes <input type="checkbox"/>	
Nursery Problems:								HepB No <input type="checkbox"/> Yes <input type="checkbox"/>	
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: <input type="checkbox"/> 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, Champ VA, Cigna, Colorado Children's Health Plan (CHP), Humana, Health First (aka Medicaid), Tricare, 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. Whenever you change insurance, be certain to check our website for the insurance companies that we contract with. When in doubt, call our Business/Billing department.

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.

Auto Pay Program

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 an encrypted merchant services vault with Instamed. We accept Visa, Mastercard, American Express, and Discover.

Your insurance company will be billed and when we receive notification 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. You may also pay your bill on your web portal.

The maximum amount that would automatically be charged to your credit card is \$250. This is the maximum per month that we will run your card on file. For continual larger balance, we may contact you for either a recurring monthly payment on account, or additional payment above and beyond the \$250.

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, however, 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 exams 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>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			