PREMIER FAMILY PHYSICIANS

PEDIATRIC DEMOGRAPHICS

Parent/Guardian Information

1. Legal Name: _____ Relationship to Patient: _____

Single (_____) Married (_____) Divorced/Single (_____) Divorced/Remarried (_____) Widowed (_____)

Previous Name: _____ Date of Birth: _____

Email Address: __ _____ D.L. # and State: _____

Home #: (____) _____ Cell #: (____) _____ Work #: (____) _____

Address:_____

Employer's Name: _____ Occupation: _____

2. Legal Name: _____ Relationship to Patient: _____

Single (_____) Married (_____) Divorced/Single (_____) Divorced/Remarried (_____) Widowed (_____)

Previous Name: _____ Date of Birth: _____

Email Address: __ _____ D.L. # and State: _____

Home #: (____) _____ Cell #: (____) _____ Work #: (____) _____

Address:_____

Employer's Name: _____ Occupation: _____

Children (Full Legal Names/Nickname) (Please check the box next to the children that are here for an appointment today)

- ☐ Name _____/_____ Sex _____ DOB _____
- ☐ Name _____/_____ Sex _____ DOB _____
- ☐ Name _____/_____ Sex _____ DOB _____
- ☐ Name _____/_____ Sex _____ DOB _____
- ☐ Name _____/_____ Sex _____ DOB _____

Type of Home: House _____ Apartment _____ Year built _____

Previous physician name _____ Practice Name _____ office #_____

Preferred pharmacy _____address_____

phone # _____

Insurance Information:

Insurance Company Name: _____

Insurance ID #: _____ Group #: _____

Insurance Claim Address _____

Policy Holder (Last, First, Middle) _____ DOB _____

Address: SAME?

Street _____Apt # _____ City _____State _____ Zip Code _____

Phone #: _____Home Work Cell/Other

SSN _____ Employer _____

Payment is due at the time services are rendered. By signing below, you agree to and understand the following policies:

HIPAA – Privacy Notice

I am aware that I may review Premier Family Physicians (PFP) HIPAA privacy notice at any time and understand that I may request a copy.

Initials: _____

PFP Medical Care Agreement

I authorize the physicians of PFP to administer medical treatment as deemed necessary. I understand that there will be a $25.00 charge for appointments not cancelled 24 hours in advance. I understand that the primary insured is financially responsible for any balance not covered by my insurance including co-pay, deductible/co-insurance, and any services excluded by my policy. I also understand that PFP will not verify insurance coverage. I also understand the primary insured will be held responsible for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service. Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits to otherwise payable to me to Premier Family Physicians, LLP

Initials: _____

Medical Care Agreement

I authorize the physicians of PFP to instruct their Physician Assistant /Nurse Practitioner and Physical Medicine Providers to assist in certain aspects of my medical care. I understand that a Physician Assistant/Nurse Practitioner is not a licensed physician and may not treat or diagnose any illness or medical condition except under the supervision/direction of a licensed physician. I understand that each time I make an appointment, if my physician is not available in a timely manner, I will be given the choice to be seen by the Physician Assistant/Nurse Practitioner... I acknowledge that it is my responsibility to inform the staff of PFP that I wish not to see the Physician Assistant/Nurse Practitioner and be scheduled with my assigned physician accordingly. I understand that I may revoke this authorization at any time.

Signature:_____ Date:_____

Electronic Communication

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, **for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication**. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

Signature:_____ Date:_____

How did you hear about us?

Word of Mouth☐ Yelp☐ Web Search☐ Facebook☐ Health Grades☐ Community Newsletter☐

Insurance Company☐ _____Other

PREMIER FAMILY PHYSICIANS

In order to help you clearly understand our policies and services, please read the following statements, and sign the bottom indicating you accept these rules:

- I understand the clinic normally uses Clinical Pathology Laboratories (CPL). If I or my insurance company prefers another lab, it is my responsibility to inform a medical staff member before the specimen is being taken so I am not billed for having lab work processed by CPL, instead of another lab.
- I understand there can be a fee for controlled substance prescriptions written without an appointment.
- I understand there may be a fee for missed appointments or appointments not cancelled within 24 hours. Please notify us as soon as possible if you cannot make your scheduled appointment.
- I understand a fee may be assessed for any paperwork or forms to be completed without an appointment and that it may take up to 10 days to be completed.
- I understand prescription renewals are to be processed through the requested pharmacy. If the prescription is mail order and requires a written prescription, it may take 3-4 business days to be processed.
- I understand that labs, x-ray reports, and other test results need to be reviewed and it may take between 3-4 business days to be reviewed by the physician/PA. A staff member will contact you sooner if the results are urgent; otherwise, you will be contacted by phone, mail or via our secure patient web portal with the results.

FeesforServices:

$12 Controlled substance prescriptions without an appointment
$15 School forms with an appointment, disability forms
$35 Attending physician statement
$50 Physician dictated letter
$75 Physician narrative

Thank you for your cooperation.

Parent/Guardian Name (please print) _____ Date of Birth _____

Parent/Guardian Signature _____ Date _____

PREMIER FAMILY PHYSICIANS

CONSENT FOR RELEASE OF INFORMATION

Patient Name:_____Date of Birth:_____

Parent/Guardian Name:_____Date of Birth:_____

Cell Phone#:_____Email:_____

Please check the sections that apply, then sign at the bottom of the page:

_____**I do not give PFP permission** to release my child's information to anyone other than myself.

or

_____**I give PFP permission** to release my child's information that includes:

_____Entire Medical Record

_____Blood Tests

_____X-rays

_____Cultures, including throat, urine and genital

_____Appointment Details

_____Billing Information

with

_____My spouse or significant other (Name _____)

_____Other family member (Name _____)

_____On home answering machine or cell phone # _____

_____On office/work voice mail # _____

I also give permission to receive all information by mail to address:

_____

_____

Signature:_____ Date:_____

(A signature is required for this form to be considered valid

PREMIER FAMILY PHYSICIANS

Patient Auto-Payment Agreement

For your convenience we are offering a patient balance payment option. This option is designed to help you pay your bill on time every time. You are not required to fill this form out if you do not wish to participate in our Auto-Payment program.

If after a claim has been submitted to my insurance company:

1) the claim is denied as a non-covered service; or
2) the charges deemed a patient responsibility by your insurance company Premier Family Physicians has my permission to charge my credit card/ debit card on file for services provided to me or my dependent.

I understand that in the event my credit card or debit card has been charged for medical services, and then my insurance company makes payment to Premier Family Physicians for those charges, the office will issue a refund or credit to my credit or debit card in the amount received from my insurance company.

I hereby authorize Premier Family Physicians and its designated payment system to charge my credit or debit card the full amount of charges for medical services provided. The amount charged will be reflected on my credit / debit card statement.

If payment is denied by my payment card company or bank, I agree to pay the entire amount promptly via another form of payment.

Patient Name: _____

Patient Date of Birth: _____

Dependent Name:

_____

_____

_____

_____

_____

Dependent Date of Birth:

_____

_____

_____

_____

_____

Signature: _____ Date: _____

(you will receive an electronic receipt via text or email for any transactions processed, provided we have your contact information)