Little Miracle Pediatrics – New Patient Information Form (Child)

CHILD	
Last Name: _____	First Name: _____
Middle: _____	Date of Birth: _____
SSN: _____	Gender: **O** Male **O** Female
Medical Insurance Name: _____	
Policy ID#: _____	Group#: _____
Name of Insured: _____	Date of Birth: _____

FATHER		
Last Name: _____	First Name: _____	Middle: _____
Address: _____	City:_____	State: ____ Zip: _____
Home Phone Number: _____	Cell Number: _____	Email: _____
Living with child? **O** Yes **O** No		
Place of Employment: _____	Work Number: _____	
SSN: _____	Date of Birth:_____	Driver's License#:_____

MOTHER		
Last Name: _____	First Name: _____	Middle: _____
Address: _____	City:_____	State: ____ Zip: _____
Home Phone Number: _____	Cell Number: _____	Email: _____
Living with child? **O** Yes **O** No	Date of Birth: _____	Drivers License # _____
Place of Employment: _____	Work Number:_____	SSN:_____

EMERGENCY CONTACT INFORMATION

Contact Name: _____

Relationship to Contact: _____

Phone Number: _____

Insurance Assignment and Release

I authorize release of any information containing my child's health care, advice or treatment for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits otherwise payable to me to the Doctor.

Responsible Party Signature: _____ Date: _____

CONSENT TO VIEW MEDICATION HISTORY

I authorize Little Miracle Pediatrics to download and view my child's Medication History.

Signature: _____ Date: _____

INSURANCE COVERAGE

The information I have provided to Little Miracles Pediatrics is true and correct to the best of my knowledge. I hereby assign any medical benefits to Little Miracles Pediatrics, and they remain in effect until revoked by me. I understand and agree that I am financially responsible for all charges not covered by my insurance.

Acknowledgment of Receipt of Notice of Privacy Practices (You may refuse to sign this Acknowledgment)

I, _____, have received a copy of this Notice of Privacy Practices.
Please print name: _____
Signature: _____ Date: _____
FOR OFFICE USE ONLY
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:
O individual refused to sign.
O Communication barriers prohibited obtaining the acknowledgment.
O An emergency situation prevented us from obtaining acknowledgment.
O Other (Please specify): _____

AUTHORIZATION FOR TREATMENT

I authorize Maria Owsik, MD, to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Maria Owsik, MD for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all copayments and charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following:

I understand that if my child's physician or any person employed by or under the direction and control of my child's physician(s) is directly exposed to my child's body fluids in any manner which may, according to the then current CDC guidelines, transmit the HIV or hepatitis B or C viruses, I will have consented by law to release of these results to the person who is exposed to my child's body fluids.

Parent/Guardian Signature: _____
Print Full Name: _____
Relationship: _____
Date: _____

In the event that I (parent/guardian) _____ cannot accompany my child to Little Miracle Pediatrics for an appointment, whether that be in person or virtual (via phone/computer/email/telemedicine platform); I authorize such persons, daycare, school, child care facility, and/or staff members of the above listed entities who are entrusted with the care, supervision, and well-being of my child _____ to initiate and/or attend such medical consultations/visits. In the event of my absence, I do hereby consent, authorize, and grant such persons/entities the power and authority to act on my behalf in medical situations that warrant swift action for the health and well-being of my child. Furthermore, authorized persons/entities listed in this document may have complete privity to medical records and/or information necessary to act on my behalf in my absence to help facilitate appointments and/or patient treatment with the aforementioned medical practice.

1. Name: _____	Relationship to child: _____
2. Name: _____	Relationship to child: _____
3. Name: _____	Relationship to child: _____
4. Name: _____	Relationship to child: _____
5. Name: _____	Relationship to child: _____

OUR FINANCIAL POLICY

As a courtesy to our patients, we participate in many health care insurance programs. Insurance is considered a method of reimbursing the patient for professional services fees paid to the doctor and is not a substitute for your responsibility of payment for services provided.

- As the patient, it is your responsibility and obligation to understand your health insurance policy benefits and obligations, including your financial obligations for the services provided and to obtain prior authorization when necessary. Initials: _____
- Health care regulations require collection of all copayments, deductibles, balances and noncovered professional fees at the time of service. Initials: _____
- If your insurance company does not pay for professional services within a reasonable time period, we have the right to bill you for the balance on your account. Initials: _____
- All copayments are collected at the time that you receive services. Insurance copayments are collected at every visit. Initials:_____
- Some insurance companies only pay a portion of the professional fees (fixed allowances or percentages). Depending on your plan, you may be required to pay any outstanding balance on your account. Initials: _____

By signing below, I acknowledge that I have read and understand the financial policy of Little Miracle Pediatrics. I accept financial responsibility for professional services and understand that I will be responsible for any unpaid balance on my account; in the event that my insurance plan does not fulfill their contract obligation.

Signature: _____ Print Name: _____ Date: _____

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

Patient Name: _____	Date of Birth: _____
Current Phone: _____	Current Address: _____
RELEASE MEDICAL RECORDS FROM:	
Name or Facility: _____	Address: _____
Phone: _____	Fax: _____
DISCLOSE MEDICAL RECORDS TO:	
Name or Facility: _____	Address: _____
Phone: _____	Fax: _____
I AM REQUESTING MEDICAL RECORDS FROM DATES: FROM: _____ TO: _____	

Please send my requested information by:

O Fax: _____ O Mail: _____ O Email: _____ (Note: It is preferred to send records via fax.)

I AUTHORIZE THE FOLLOWING TYPES OF INFORMATION TO BE RELEASED

O All medical records **O** Labs/Pathology/Imaging **O** Immunizations/Vaccines **O** History/Physicals

O Specialist Consultations **O** Hospital Records **O** Operative Notes **O** Growth Charts

O Medications **O** Photos **O** Billing Statements **O** Other: _____

Your initials are required to release the following:

_____ Psychiatric/Psychological Evaluations and Notes _____ Drug/Alcohol Results _____ HIV/STD Report

PURPOSE OF DISCLOSURE (PLEASE SPECIFY)

O Transfer of Care **O** Continuity of Treatment **O** Personal Use **O** Other: _____

Expiration Date: _____ (If left blank, this authorization will expire one year from the date signed.)

I recognize that the health information disclosed may contain information that is privileged and protected by law, and I specifically consent to the disclosure of such information. I understand I have the right to inspect or copy the information to be used/disclosed as permitted by federal law. All records obtained will be used solely for professional purposes and will remain confidential and may not be disclosed to third parties. This authorization may be revoked by me in writing to Little Miracle Pediatrics at any time. A written

cancellation in the future will have no effect on any records that may have been released prior to the receipt of the written cancellation. Information released may be subject to redisclosure by the recipient. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected. I understand that a copy of this release is as valid as the original and I may also receive a copy of this form after I sign it. In consideration of this consent, I hereby release the above parties from any and all liability arising therefrom.

Signature of Patient/Parent/Legal Guardian: _____
Print Name of Patient/Parent/Legal Guardian: _____
Relationship to Patient: _____ Date: _____

Notice: There may be a cost for producing medical records in accordance with State and Federal Law.