

**PATIENT INFORMATION FORM**

Please Complete This Entire Form (list all children the information applies to)

**PLEASE PROVIDE A COPY OF ANY DOCUMENTS RELATED TO CUSTODIAL RIGHTS FOR THE PATIENT'S RECORD**

PATIENT LAST NAME: GENDER: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	PATIENT FIRST NAME:	MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME: GENDER: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	PATIENT FIRST NAME:	MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME: GENDER: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	PATIENT FIRST NAME:	MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME: GENDER: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	PATIENT FIRST NAME:	MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME: GENDER: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	PATIENT FIRST NAME:	MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
MAILING ADDRESS:	CITY:	STATE:	ZIP:
PHYSICAL ADDRESS ( <i>If different</i> ):	CITY:	STATE:	ZIP:
PRIMARY PHONE: ( )	CELL PHONE: <input type="checkbox"/> <i>Check if same as Primary</i> ( )	WORK PHONE: ( )	EXTENSION:
PREFERRED PHARMACY: Name, Address and Phone Number		ENABLE FOR PATIENT PORTAL: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
RACE: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hawaiian Native/ Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Declined to Specify <input type="checkbox"/> Other (Details) _____			

**GUARANTOR INFORMATION**

(Individual responsible for bills and payment – If you are an 18+ year old patient, this would be YOUR name)

GUARANTOR LAST NAME:	GUARANTOR FIRST NAME:	MIDDLE INITIAL:	RELATIONSHIP TO PATIENT ( <i>Check all that apply</i> ): <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Self <input type="checkbox"/> Other ( <i>Specify</i> ):	
STREET ADDRESS: <input type="checkbox"/> <i>Check if same as patient</i>	CITY:	STATE:	ZIP	
PRIMARY PHONE: ( )	CELL PHONE: <input type="checkbox"/> <i>Check if same as Primary</i> ( )	WORK PHONE: ( )	EXTENSION:	
E-MAIL ADDRESS: <input type="checkbox"/> None	SOCIAL SECURITY #:	DATE OF BIRTH ( <i>mm/dd/yyyy</i> ):		
GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	EMPLOYER NAME:	EMPLOYER PHONE #: ( )		
<i>Receive Statements via:</i> <input type="checkbox"/> Mail <input type="checkbox"/> Email		MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: <input type="checkbox"/> Yes <input type="checkbox"/> No		

**OTHER PARENT**

PARENT LAST NAME:	PARENT FIRST NAME:	MIDDLE INITIAL:	RELATIONSHIP TO PATIENT ( <i>Check all that apply</i> ): <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Self <input type="checkbox"/> Other ( <i>Specify</i> ):	
STREET ADDRESS: <input type="checkbox"/> <i>Check if same as patient</i>	CITY:	STATE:	ZIP:	
PRIMARY PHONE: ( )	CELL PHONE: <input type="checkbox"/> <i>Check if same as Primary</i> ( )	DATE OF BIRTH ( <i>mm/dd/yyyy</i> ):		
E-MAIL ADDRESS:		MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: <input type="checkbox"/> Yes <input type="checkbox"/> No		

CONTACT NAME:	RELATIONSHIP TO CHILD:	CONTACT PHONE:
CONTACT NAME:	RELATIONSHIP TO CHILD:	CONTACT PHONE:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
May pick up prescriptions	May pick up forms	May pick up medical records
<input type="checkbox"/> Yes <input type="checkbox"/> No		
May speak to nurse or doctor for medical advice		

**INSURANCE INFORMATION ONLY IF CURRENT INSURANCE CARD NOT PRESENT**

*(Please present all current insurance cards to the Front Desk)*

I HAVE INSURANCE: <input type="checkbox"/> Yes <input type="checkbox"/> Yes, but pending, not active, or you're not contracted <input type="checkbox"/> No ( <i>Self Pay</i> )			
PRIMARY INSURANCE:		SECONDARY INSURANCE:	
SUBSCRIBER:	RELATION TO PT:	SUBSCRIBER:	RELATION TO PT:
Policy ID:	Group ID:	Policy ID:	Group ID:
GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
DATE OF BIRTH:	SOCIAL SECURITY #:	DATE OF BIRTH:	SOCIAL SECURITY #:

**CONFIDENTIAL COMMUNICATION**

*(I hereby request to receive confidential communications from North Point Pediatrics in the following manner)*

<p><b>PHONE MESSAGES – Please leave messages as follows</b> (Check All That Apply)</p> <p><b>Primary Phone:</b>   <input type="checkbox"/> Mom   <input type="checkbox"/> Dad   <input type="checkbox"/> Both</p> <p style="padding-left: 40px;"><input type="checkbox"/> Self (for 18+ year old patients)</p> <p style="padding-left: 20px;"><input type="checkbox"/> BRIEF MESSAGE   <input type="checkbox"/> DETAILED MESSAGE</p> <p><b>Cell Phone:</b>   <input type="checkbox"/> Mom   <input type="checkbox"/> Dad   <input type="checkbox"/> Both</p> <p style="padding-left: 40px;"><input type="checkbox"/> Self (for 18+ year old patients)</p> <p style="padding-left: 20px;"><input type="checkbox"/> BRIEF MESSAGE   <input type="checkbox"/> DETAILED MESSAGE</p>	<p align="center"><b>APPOINTMENT CONFIRMATIONS/RECALLS</b></p> <p><b>CONTACT: (Check one)</b></p> <p style="padding-left: 40px;"><input type="checkbox"/> Mom   <input type="checkbox"/> Dad   <input type="checkbox"/> Self (for 18+ year old patients)</p> <p><b>VIA THE FOLLOWING METHOD: (Check one)</b></p> <p style="padding-left: 40px;"><input type="checkbox"/> Text message</p> <p style="padding-left: 40px;"><input type="checkbox"/> Home/Cell Phone – automated call</p> <p style="padding-left: 40px;"><input type="checkbox"/> Email address</p> <p>If needed, I agree to participate in Telehealth visits through a HIPAA Compliant platform.   _____YES   _____NO</p>
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**Telephone. Email Contacts**

*I hereby consent and agree that: (1) anyone acting on behalf of North Point Pediatrics (herein known as "NPP") may contact me as necessary regarding my account (including for collections purposes or related to insurance coverage); (2) any and all of NPP's contacts with me may be made via text message or with an automated dialing and announcing or similar device, and via email; (3) NPP may contact me at any telephone number I provide to them, whether a residential, business number, or cellular number; (4) I have an established business relationship with NPP and that NPP may contact me at the telephone number or email address I provide to them, in any of the ways described above. I understand that, if I accept now, I may change at any time by notifying NPP staff.    **Accept**    **Decline***

**Initials:** \_\_\_\_\_

**Release of Protected Health Information in Emergency Situation**

*I understand that my protected health information may be released as my physician determines appropriate in an emergency situation.*

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:**

I hereby authorize North Point Pediatrics to examine and treat my child when necessary. I also authorize the release of my protected health information, acquired in the course of examination to carry out treatment, payment and health care operations of my child. I hereby authorize payment directly from my insurance company to the physicians of NPP for medical treatment(s) provided to my child. I understand that payment in full of my responsible portion is required at the time of visit. If North Point Pediatrics is not a provider on my insurance, full payment is due on the date of service. If North Point Pediatrics is a provider on my insurance, then any deductibles, copays, or percentages are due at the time of service. Additionally, if I miss a scheduled appointment, I understand I may be charged \$35. If I miss two scheduled appointments I may be charged \$75. ***By signing below, I am acknowledging that I have read and understand the above statements.***

\_\_\_\_\_  
Parent, Legal Guardian, or Patient (18 or older) Printed Name

\_\_\_\_\_  
Parent, Legal Guardian, or Patient (18 or older) Signature

\_\_\_\_\_  
Date Signed

## **Information from the American Academy of Pediatrics**

### Patient Education on Billing

As you may know, there are very specific regulations about billing for health care services. As your health care provider, we are obligated to follow those regulations in how we report services provided to you. Additionally, every insurance plan may have different rules that vary from insurer to insurer and may even vary between plans of the same insurer.

- All physicians/providers must report services using a variety of codes to tell the insurance company what was done and why.
- It is not uncommon for patients in the course of a visit to receive management and treatment services for a separate and specific problem, as well as routine or preventive services at the same visit. This results in billing a sick visit with a well visit.
- Both services must be reported to the insurance company and may result in an additional co-payment or charge as per the insurer's plan rules which we are obligated to follow.
- There are many different insurance companies and plans; addressing a problem may trigger a co-payment or additional charges to your account.
- Your financial responsibility is determined by the rules of your insurance company, which we are obligated to follow.
- If you have questions, please check with your insurance plan.

We are dedicated to providing the best possible care for you and your family and to being respectful of your time. If our business office can help, please call them at (678) 336-1409.

**YOUR COPY TO KEEP**