# Notice of Privacy Practices Receipt of Acknowledgement
# and
# Consent to Treat

This form acknowledges that this patient/parent/guardian of Children First Pediatrics has received a copy of this clinic's HIPAA Privacy Policies. You may refuse to sign this acknowledgement.

I have been offered a copy of the Notice of Privacy Practices, detailing how my child's health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

In the case of records requested by, and/or for myself, this form also acts as a signature verification form.

__________________________________ __________________________________
Child's Name Child's Name

__________________________________ __________________________________
Child's Name Child's Name

__________________________________ __________________
Parent/Guardian Signature Date

## Consent for Treatment

I hereby authorize Children First to perform the required medical treatment considered advisable for the patient. I realize that no guarantees to the outcome of the medical treatment, but I may expect the medical treatment to be reasonably sound by accepted medical standards.

Parent / Guardian Signature ____________________________________

I also authorize the following persons to accompany my child/children named above to their appointments and authorize them to act in my place with respect to any and all medical matters if I am not able to accompany my child. *(Note: you are not required to authorize any other individuals if the patient will always be accompanied to his/her appointments by a parent or legal guardian.)*

| Name | Phone # | Relationship to patient |
| --- | --- | --- |
| | | |
| | | |
| | | |

# CHILDREN FIRST PEDIATRICS Family Registration Form

**PLEASE PRINT CLEARLY AND COMPLETE ALL BLANKS**

**□ Dr. Applegate** **□ Dr. Koch**

| CHILDREN'S FULL LEGAL NAMES (first and last) | SEX | BIRTH DATES |
|---|---|---|
| 1. ______________________________ | □M / □F | ______/______/______ |
| 2. ______________________________ | □M / □F | ______/______/______ |
| 3. ______________________________ | □M / □F | ______/______/______ |
| 4. ______________________________ | □M / □F | ______/______/______ |
| 5. ______________________________ | □M / □F | ______/______/______ |
| 6. ______________________________ | □M / □F | ______/______/______ |

## PARENT OR GUARDIAN INFORMATION

Responsible Party Name:________________________________

Birthdate: _____/______/_______ SS#: ______-____-_______

Home Address: ________________________________________

City: ________________________ State: _______ Zip:________

Home Phone: (______)_______-__________

Cell Phone: (______)_______-__________

Work Phone: (______)_______-__________

Occupation:____________ ______________________________

Employer: ____________________________________________

Current Insurance Carrier:_______________________________

**Patient(s) live with** _________________________________

Other Parent or Guardian:________________________________

Birthdate: _____/______/_______ SS#: ______-____-_______

Home Address: ________________________________________

City: ________________________ State: _______ Zip:________

Home Phone: (______)_______-__________

Cell Phone: (______)_______-__________

Work Phone: (______)_______-__________

Occupation:____________ ______________________________

Employer: ____________________________________________

E-Mail Address:_________________________________________

**Referred by;**______________________ __________________

## OTHER CONTACT INFORMATION

In case of emergency please contact (other than above) _______________________________________

Relationship to patient______________________________ Phone (______)______-__________

Telephone / E-mail contact authorization: In compliance with Federal HIPAA privacy Regulations, will you authorize Children First Pediatrics to leave a detailed message on your answering machine / voice mail / e-mail that may include appointment reminders, lab and x-ray results and other private health information protected by privacy rules. □ yes □ no

If yes: list phone number (s) we can leave a message on and / or email addresses:

(_____) _____-_________ (_____) _____-_________ email: _________________________________________

This authorization will remain in effect until changed or terminated by you or another legal guardian authorized to do so by submitting a written request to Children First Pediatrics in person or by mail.

Parent/Guardian Signature __________________________________________________ Date ______/______/__________

# CHILDREN FIRST PEDIATRICS

Consent to Obtain Medication History

Children First Pediatrics has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your child's / children's medication history.

A medication history is a list of prescription medicines that we or other doctors have recently prescribed for your child/ children. This list is collected from a variety of sources, including your health insurer and any pharmacies that you use. An accurate medication history is very important to helping us treat your child / children properly and in avoiding potentially dangerous drug interactions. By signing this consent form you give us permission to collect and give your pharmacy and your health plan permission to disclose information about your child / children's prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your child's medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything your child / children are taking, and for you to point out to us any errors in your medication history.

I give permission for Children First Pediatrics to obtain my child / children's medication history from my pharmacy, my health plans and other healthcare providers who care for my child /children.

| Child's Name(s) | Birthdate |
|---|---|
| _______________________________________________ | ____________________ |
| _______________________________________________ | ____________________ |
| _______________________________________________ | ____________________ |
| _______________________________________________ | ____________________ |
| _______________________________________________ | ____________________ |
| _______________________________________________ | ____________________ |

__________________________________________________ _____________________

Parent/ Guardian Signature Date

# CHILDREN FIRST PEDIATRICS FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we wish to help you receive your maximum allowable benefits. To achieve this, we need your understanding and assistance with our financial policy.

***Payment*** is required at the time of service. We accept cash, check or credit card (Visa or MasterCard).

For patients with ***private or no insurance***, full payment is required at the time of service unless other arrangements have been made.

For patients with ***insurance***, co-payment is required at the time of service. The amount of co-payment varies with different plans. Please bring your insurance card to every appointment for verification.

Please remember, insurance is a contract between you and your health insurance company. While the filing of insurance claims is a courtesy that we provide, ***all charges not covered by your insurance company are your responsibility.***

Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your ***remittance is due within 10 business days*** of your receipt of your bill.

For patients on ***Medicaid***, the card is required at the time of service. Patients are responsible for payment of services provided no card is received. No well-child or non-medically urgent care will be given without this card.

***Bills unpaid for more than 90 days*** may be turned over to a collection agency unless other arrangements have been made. Accounts that are turned over to collections may result in dismissal from the practice. You will be responsible for both the unpaid bill and the collection agency fee.

For scheduled appointments, ***prior balances*** must be paid in full prior to the visit.

A **$25 fee** will be charged for any ***returned checks*** for insufficient funds.

If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by our business office staff.

Please help us serve you better by keeping scheduled appointments. Multiple missed appointments may result in dismissal from the practice.

If you are ***over 15 minutes late for your appointment***, we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.

Some ***monthly prescriptions refills*** cannot be made over the phone. For those prescriptions that can be refilled, we require 48 hour notice during regular business hours. Please plan accordingly.

**I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above. I have received a copy of this financial policy if requested.**

Patient Name(s) ____________________________________________________________________________

Responsible Party Members Name _______________________________Date ______________________

Responsible Party Signature____________________________________ Relationship ___________________

## Our Immunization Philosophy

Children First Pediatrics is dedicated to providing the highest quality of evidence-based medical care to our patients. The practitioners at Children First Pediatrics feel that immunizations are an essential part of high quality care for children. Proper immunizations protect the health of the individual child, and protect everyone in the community as a whole. When you immunize your child, you are not only protecting your child from serious disease, but you are also helping to protect your entire community.

We understand that many parents have concerns about immunizations; however, as physicians we feel there is no strong scientific evidence to withhold immunizations from your child, unless medically contraindicated. Given our philosophy, for the health of your child and for the health of the community at large, we feel that any decision to not immunize your child, or to alter the evidence-based vaccine schedule, is not compatible with a trusting physician-patient relationship we value in our office. Because we believe that any decision to not immunize or to significantly alter the vaccine schedule puts your child at risk for preventable diseases and increases the health risks for our youngest patients, Children First Pediatrics reserves the right to respectfully decline or discharge under-immunized patients from our practice.

Our physicians are happy to discuss this policy with you.

By signing below you agree that you have reviewed the Immunization Philosophy for Children First Pediatrics.

______________________________________ ____________

Signature Date

______________________________________

Printed Name