Prime Pediatrics

Patient's Name _____ Birthdate _____
LAST FIRST MI

Address _____ City _____ State _____ Zip _____

Nickname _____ Sex **M F** Race _____

Home Phone _____ Cell Phone _____

E-Mail _____ Referred By _____

Siblings Name _____ Birthdate _____ Sex **M F**

Name _____ Birthdate _____ Sex **M F**

Name _____ Birthdate _____ Sex **M F**

Mother/Guardian_____ Father/Guardian_____
SSN_____ DOB_____ SSN_____ DOB_____
Address_____ Address_____
City_____ State_____ Zip_____ City_____ State_____ Zip_____
Home# _____ Home# _____
Cell#_____ Work#_____ Cell#_____ Work#_____
Employer_____ Employer_____
Occupation_____ Occupation_____

Emergency Contact_____ Phone_____
Relationship to Patient_____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Policy Holder Name _____	Policy Holder Name _____
Insurance Company_____	Insurance Company_____
Address_____	Address_____
_____	_____
Phone_____	Phone_____
Effective Date_____ Copay_____	Effective Date_____ Copay_____
ID/Contract#_____	ID/Contract#_____
Group/Plan#_____	Group/Plan#_____

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Copayments are due at the time of service. There is a $5 billing fee for all copayments not collected at the time of service. Whether are not your insurance pays in full, a portion, or nothing at all for services rendered, is a matter between you and your insurance carrier. Any unpaid balance is due within 30 days of treatment date, unless other arrangements have been made. Finance charges at the rate of 1.5% per month will be assessed for all patients balances not paid within 30 days. ***ALL THE LABORATORY TEST DONE IN THE OFFICE IS THE PATIENT'S RESPONSIBLITITY.*** Payment is accepted in the form of cash, check, money order, Visa or MasterCard.

There is a $25 charge for all returned checks. There is a $25 charge for all missed appointments cancelled less than 24 hours in advance. If you need to cancel an appointment, you must call the office at least 24 hours in advance.

If you are more than 15 minutes late for your scheduled appointment we cannot guarantee you will be seen at that time and you will be charged $25 for the missed appointment.

Initials _____

PAYMENT AUTHORIZATION

*I, _____, hereby authorize Prime Pediatrics, LLC to apply for benefits on minor's behalf for covered services rendered. I request payment to be made directly to Prime Pediatrics, LLC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or, any related claim to the above named billing agent. I permit a copy of this authorization to be used in place of the original. Either the above-named carrier or I may revoke this authorization at any time in writing. I agree to be legally responsible for any and all charges incurred for the patient named above.

Please sign and date: *_____

SIGNATURE OF SUBSCRIBER/BENEFICIARY DATE

PRIME PEDIATRICS, LLC.
NOTICE OF PRIVACY PRACTICES

We are required by law to protect the privacy of your protected health information (PHI). This document describes how medical information about you may be used and disclosed. It also explains how you can gain access to your medical information and who to contact should you have any complaint. Please read this document carefully and sign the bottom of the form to acknowledge that you have received it.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by our physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: Your PHI may be shared with employees and contractors of the provider, or with other health care providers who are treating you or consulting in your care.

Payment: Your PHI may be shared with your insurer or other third-party payer who is responsible for paying all or part of the cost for your care.

Health Operations: We may use and disclose information that is necessary for our operation, such as internal quality assessments, contacting other health care providers about treatment alternatives, licensing, employee review activities, etc. We may use sign in sheet at the registration desk and we may call you by name in the waiting room when the physician is ready to see you.

We may use or disclose your PHI in the following situations without your authorization, including: public health issues as required by law, communicable disease, health oversight, abuse or neglect, FDA requirement, legal proceedings, law enforcement, coroners, funeral directors, organ donations, research, criminal activity, military activity, national security, and worker's compensation. We are required by law to make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

You may be asked to sign a specific authorization for release of medical records, which will authorize us to make specific disclosures that are not covered under the above sections. You may revoke any consent or authorization provided to us by giving a written notice of revocation.

Your Rights:

1. You have the right to inspect and copy your health information.
2. If you feel that the health information we have about you is incomplete or inaccurate, you have the right to request an amendment to your medical records. The request must be made in writing with the reason for the request. If we do not agree with your request, you have the right to ask that your statement be place din the medical record.
3. You have the right to find out how your health information is used and to whom it is disclosed. You may request an accounting of your medical record disclosures made by us, except for the disclosures made for treatment, payment and health care operations.
4. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to a specific person, or for notification purpose as described in this Notice of Privacy Practices. Your request must be in writing and must states the specific restriction requested and to who you want the restriction to apply. Your physician is not obligated to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.
5. You have the right to receive a paper copy of this notice.

We reserve the right to change the terms of this notice and will inform you by mail of any changes.

Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our HIPAA Compliance Officer in person, by phone or in writing at the office address. We will not retaliate against you for filing a complaint.

Please acknowledge that you have reviewed this notice of Privacy Practices by signing below.

Name of Patient: _____

Signature of Parent/Legal Guardian:_____ Date:_____