PEDIATRICS PLUS, P.C.

PATIENT ANNUAL UPDATE INFORMATION

PATIENT NAME: _____ DOB: _____

GENDER: _____ SS# _____ PATIENT LIVES WITH: _____

RACE: _____ LANGUAGE: _____ EMAIL: _____

ADDRESS (APT#): _____CITY /STATE/ZIP:_____

PRIMARY PHONE #: _____ 2ND PHONE #: _____

INSURANCE: _____ POLICY #: _____ GROUP# _____

INSURANCE SUBSCRIBER: _____ DOB: _____

MOTHER'S NAME: _____ DOB: _____

FATHER'S NAME: _____ DOB: _____

DHR OR OTHER CUSTODY: _____ PHONE: _____

DHR CASEWORKER: _____ COUNTY: _____ PHONE: _____

EMERGENCY CONTACT (OTHER THAN PARENT):

NAME: _____ PHONE: _____ RELATIONSHIP: _____

NAME: _____ PHONE: _____ RELATIONSHIP: _____

AGREEMENT TO PAY: I, undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court cost, if such be necessary.

PERMISSION FOR CHILDREN TO BE SEEN

WITH NON-PARENT/GUARDIAN FORM (HIPAA)

PATIENT'S NAME: _____ DOB: _____

The following people have permission to bring my child to Pediatrics Plus, P.C. to be seen and to call the triage staff of Pediatrics Plus, P.C. to get medical information via the telephone for my child. They have full authority to act in my behalf should authorization be necessary for testing or treatment. They may also receive financial information such as the balance on my account. I understand that if any person who is not on this list, calls Pediatrics Plus, P.C. or brings my child to Pediatrics Plus, P.C. except in the case of an emergency, Pediatrics Plus, P.C. will not speak with this person nor see my child in the office. I understand that I can ask that the following people not be given any financial information regarding my account and I will note this restriction beside their name below if I do not wish them to receive this information.

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

APPOINTMENT REMINDERS, ETC

We may contact you by sending text messages/emails, using any cell number or email address you provide to us to remind you of your appointment. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable. You agree Pediatrics Plus, PC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you.

You also agree, in order for us to service your account or to collect monies you may owe, Pediatrics Plus, PC and/or our agents may contact you by telephone at any telephone number associated with your account including wireless telephone numbers, which could result in charges to you.

I/we have read this disclosure and agree that Pediatrics Plus, PC, its employees and/or agents may contact me/us as described above. Please provide us with the information listed below:

Patient Name/DOB: _____

Phone Carrier: _____ Cell #: _____

Email Address: _____

_____ _____

NAME OF PARENT/GUARDIAN DATE

_____ _____

SIGNATURE OF PARENT/GUARDIAN WITNESS