Demographic Information

Last Name ______________________________ First Name_______________________ Middle _____________________

Preferred Name ______________________________ AKA ____

Date of Birth ____________________________ Time of Birth (Newborns only) ____:_____AM/PM Sex: M / F

Preferred Pharmacy ____

Email Address ____ (this will give you access to your child's chart)

Primary Language ___ English ___ Other______________________________

Mailing Address ___________________________________ Home Address (if different) _________________________

Zip Code _______________ City ____ State ___________

Home phone ____________________________ Cell phone _______________________

Preferred Communications: Mail____ Home phone____ Cell phone ____ Email____

Race __________________________________ Ethnicity ____

Associated Party/Responsible Party Name

Name ____ Association _______________________________________

Relationship to patient ____ Date of Birth ___________________________

Address____ City ___________________ State _____ Zip ____________

Preferred Telephone number ______________________________

Primary Insurance Information

Policy Holder's Name ____ Date of Birth ______________________________

Policy Holder Social Security Number _____________________________ Relationship to patient _____________________

Insurance Company ____

Patient ID # ____ Group ID # _______________________________

Employer ____ Occupation ______________________________

Secondary Insurance Information (if applicable)

Policy Holder's Name ____ Date of Birth ______________________________

Policy Holder Social Security Number _____________________________ Relationship to patient _____________________

Insurance Company ____

Patient ID # ____ Group ID # _______________________________

Employer ____ Occupation ______________________________

Assignment and Release

I, the undersigned, certify that I, or my dependent, have insurance coverage with the above insurance company, and assign directly to Lisa Callahan CPNP all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Lisa Callahan CPNP to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ______________________________ **Relationship to patient**__________________

You are responsible for all deductible, co-pays, non-covered services, co-insurance, and items considered "not medically necessary" by your insurance company. **Your insurance plan** may require that you pay co-payments and co-insurance amounts on the day of your appointment. If we are asked to bill you for your co-pay, there will be an additional $10.00 charge. The remaining balance must be taken care of within 30 days of notice from the insurance company. If you make payments exceeding your balance, your account will have a credit balance unless you request a refund. If payment cannot be made at each visit, notify the front-desk to make other arrangements.

Returned checks will be charged an additional $25.00 fee, and must be taken care of within 30 days or will be subject to collections.

Insurance Billing

As a courtesy, we will bill your insurance for you. If the insurance company has not paid within 90 days, the bill will be your responsibility unless it was our error causing the delay; it is your responsibility to contact your insurance company with any questions as we are not able to do this on your behalf.

Missed Appointment Policy

We have set-aside the time for your appointment. In lieu of charging a fee for missed appointments, we reserve the right to dismiss any person who does not keep an appointment or cancel within 24 hours of your appointment time.

I acknowledge by signing that I understand and agree to the above. If you have any questions before signing, please ask for assistance.

Signature of Responsible Party ____ **Date** _______________________

Notice of Privacy Practices: Acknowledgement of Receipt

Acknowledgement of Receipt, by signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Lisa Callahan CPNP. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. Our *Notice of Privacy Practices* is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at http://grantspasspediatrics.com or on request from your health care team.

I acknowledge receipt of the *Notice of Privacy Practices* of Lisa Callahan CPNP.

Signature of Responsible Party ____ **Date** ___________________

For office use only: Inability to obtain acknowledgement and reason why not obtained. _______________________

THIS PAGE MUST BE COMPLETED BEFORE PATIENT CAN BE SEEN.