Pediatric Patient LLC

Pediatric Patient Information

Full Name: _____ Date of Birth: _____ Gender: M / / F

Full Name: _____ Date of Birth: _____ Gender: M / / F

Full Name: _____ Date of Birth: _____ Gender: M / / F

Full Name: _____ Date of Birth: _____ Gender: M / / F

Full Name: _____ Date of Birth: _____ Gender: M / / F

Language: _____ Race: _____ Phone: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Pharmacy_____

Responsible Party (Parent or Gardian)

Full Name: _____ Date of Birth: _____ Gender: M / / F

Billing Address: _____ _Phone:_____

City: _____ State: _____ Zip: _____Social Security: _____

Relationship to Patient:_____ Employer: _____

Email Address: _____

Why do we want your email? Providing our office with your email will allow us to web enable your account through a system known as Patient Portal. Using Patient portal, you can request appointments onllne, you can email questions to office staff, view lab work and imaging, access visit sum manes showing diagnoses, medications, dosage, referral history, and email reminders. After setting up a password in the Patient Portal you will be able to be able to download the Healow app. This will provide you with access to your child's health information from your mobile device.

Emergency Contact

Full Name: _____Date of Birth: _____Relationship to Patient: : _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Insurance INformation (Primary Carrier of the Insurance)

Primary Insurance:_____ Insured ID#: _____

Insured Name: _____ DOB: _____Social Security: _____

Secondary Insurance: : _____ Insured ID#: _____

Consent to treat and to disclose Protected Health Information: I authorize the physician or physicians in charge of the care of the above-named patient to administer anesthetics and/or medications and to preform such operations and/or diagnostics procedures as may be deemed necessary by the physician for the diagnosis and treatment of this patient.

The practice's Written Privacy Notice provides detailed information on how we may use and disclose protected health information. By signing this consent form, you acknowledge that you have received a copy of the Written Privacy Notice and are in agreement with our use and disclosure of protected health information for treatment, payment, and healthcare operations. Patients injured at work typically obtain information through their adjusters or employer.

I have read and understand the above statements. Affixing my signature to this form represents my receipt of the Written Privacy Notrce, my consent to treatment, and the above Irsted uses of protected health information.

Signature of Responsible Party:_____ Date: _____

PETTIT PEDIATRICS

1360 W HWY 40

VERNAL, UT 84078

P) 435.789.7337

HIPPA Acknowledgement

I hereby acknowledge that I have had the opportunity to review and/ or receive a copy of HIPPA Notice of Privacy Practices for Ethan Pettit.

Authorization

My signature below authorized the staff of Dr. Ethan Pettit to verbally (by telephone or in person) share all of my medical information without limitation with the following individuals:

Emergency

Contact: _____Relationship: _____Phone Number:_____

Name: _____Relationship: _____Phone Number:_____

Name: _____Relationship: _____Phone Number:_____

Name: _____Relationship: _____Phone Number:_____

Print Patient Name::_____Date of Birth:_____

Signature:_____ Date: _____

This form does not entitle these persons to copies of medical records.
Consent expires with the end of my care with Dr. Ethan Pettit.

Pediatric Patient LLC

FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us as your health care provider. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement. which you must read and sign prior to any current and future medical evaluation or treatment in this office. All patients must also complete the informaion and insurance form before seeing a provider.

1. Each patient is responsible for his or her own bill.
2. Payment of all insurance co-payments and deductibles are required at the time medical services are rendered. If this is not financially possible you will need to make payment arrangements with our billing office prior to any medical evaluation or treatment. We accept cash, check, and most major credit cards.
3. Palients who have no insurance are required to pay 100% of services rendered at each visit. If this is impossible you will need to make payment arrangements with our billing office prior to any medical evaluation or treatment. We accept cash, checks, and major credit cards. We do offer same day discount on the initial office visit, not including any additional services, of 20% for self-payment visits.
4. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment oi your insurance claim.
5. You are responsible for knowiny what your insurance covers and the providers and networl\(s} covered under your health insurance plan. Any service provided, but not covered by your insurance company, will be your responsibility to pay.
6. If your insurance company has not paid your full account within 90 days, you must pay the outstanding balance without further delay.
7. Monthly payments are required on all acccunls with outstanding balances. A monthly finance charge of $1^{3/4}$% per month (21% annual rate} will be charged to the amount not paid after 90 days, with a minimum charge of $50 per month. By signing below, you agree to pay collection costs up to 40% with or without suit and/or reasonable attorney fees on any delinquent balance, if referred to any agency or attorney for collection or suit.
8. A $30 fee will be charged on all returned checis.

USUAL AND CUSTOMARY RATES

Our rates for medical services reflect the usual and customary rates in the community. Unless we have accepted an alternate fee schedule from your instance, you are responsible for payment regardless of any insurance company·s arbitrary determination of usual and customary r.;tes for medical services

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize this office to release all information concerning my medical treatment to my insurance carriers and to requesting referring providers (if any).

AUTHORIZATION TO PAY BENEFITS

i further authorize and direct said agency, attorney or insurance company to pay from the prceeds of benefits of any recovery of insurance payments in my case. directly to the provioers of this office, for their professional services rendered. I understand this in no way relieves me fwm my personal responsibility ior paying my provider when a statement is rendered. It 1s under:;tood that tr.e signing of this form does not prohibit customary monthly billings.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**