# PEDIATRIC GASTEROENTEROLOGY ASSOCIATES

## PATIENT INFORMATION (PLEASE PRINT)

| | | | | |
|---|---|---|---|---|
| Patient Name | [ ] Male [ ] Female | DOB | SS# | |
| Street Address | | City | State | Zip |
| Home Phone | Cell Phone | Contact Email | | |
| Race (please check) [ ] American Indian or Alaskan [ ] White [ ] Black [ ] Asian [ ] Hispanic [ ] Native Hawaiian<br>Primary Language _____ Will you need an interpreter for your visit? [ ] Yes [ ] No | | | | |
| Referring Physician | Phone | City where seen | | |
| Responsible Party | Relationship to Patient | Phone | | |
| Street Address | City | State | Zip | |

## PARENT(S) OR GUARDIAN(S) INFORMATION

| | | | |
|---|---|---|---|
| Patient lives with: [ ] Father [ ] Mother [ ] Other<br>Name and Relationship : | | | |
| Mother's Name | | Father's Name | |
| SS# | DOB | SS# | DOB |
| Place of Employment | | Place of Employment | |
| Work # | Cell # | Work # | Cell # |
| Email | | Email | |

## INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| Primary Insurance | | Secondary Insurance | |
| Policy Holder's Name | | Policy Holder's Name | |
| Policy # | | Policy # | |
| Group # | DOB | Group # | DOB |
| Relationship to child: | | Relationship to child: | |

Patient Name:_____ Date: _____

## EMERGENCY CONTACT

| | | |
|---|---|---|
| Someone who does not live in the home: | | |
| Home # | Cell# | Work # |

## APPOINTMENT REMINDERS

We would like to make sure you get reminders of scheduled appointment by texts. To do so, please list the cell phone number where you would like to receive texts: Cell Carrier:

## INFORMATION SHARING

The following people are authorized to receive information on :
(patient's name)_____

| | |
|---|---|
| Name: | Relationship: |
| Name: | Relationship: |
| Name: | Relationship: |
| Name: | Relationship: |

## RELEASE OF INFORMATION

I authorize the release of medical information on the child to any physician or insurance company. I hereby assign all insurance benefits for services rendered. I acknowledge that I am totally responsible for all charges for services rendered to the child, including services under the Non-Covered Routine Services Policy.

Child: _____ Signature of parent or guardian: _____

## AUTHORIZING CARE

As Pediatric Specialist, we want to provide your child the best care possible. There may be certain services or tests that the Physician believes to be medically necessary that may not be covered by your insurance contract. If you have any questions about whether a service is covered, and the rights that are available to you, the benefits office of your health plan should be happy to assist you.

I, the parent or guardian of the above child, do hereby authorize Pediatric Gastroenterology Associates, P.C. and its physicians to give to the child any treatment that such physicians deem necessary for his/her health.
Initial_____ Date_____

## HIPPA RIGHTS

I acknowledge my rights under HIPPA:

Signature: _____ Date:_____

Patient_____ DOB _____

**Please read and initial.**

As a courtesy to our other patients and staff members, we ask that you please turn off your phone when you enter our office. _____

A copy of the patient's insurance card is required on each and every visit to us. It is the patient's responsibility to make sure that any insurance information given to our office is correct and current. Failure to provide such information will result in patient financial responsibility for all services. It will be your responsibility to list a physician if your insurance requires a primary care physician. _____

Co-payments and deductibles for participating insurances are due at the time of service. (Our contract with your insurance company states that we will collect a co-pay every time a patient presents to the office.) If you disagree, please contact your insurance company for verification. We may ask that non-emergent appointments be rescheduled if copayment is not paid. _____

We are not party to any legal agreements between divorced or separated parents. The parent or guardian who brings the child to the office must provide insurance information and pay any co-pay or deductibles. _____.

Our physicians strive to keep your wait to a minimum and our patients are scheduled accordingly. We therefore request that you arrive promptly at your scheduled time. If you are 15 minutes late for your appointment, it may be necessary to rescheduled out of courtesy to the other patients that are being seen that day. _____

We ask that you keep your scheduled appointments and arrive on time or notify us within twenty-four (24) hours in advance of cancellations. This courtesy on your part will allow us to accommodate other patients who may need to see our providers. We will continue to make every effort to accommodate your scheduling needs. If notice is not given or if you do not keep your scheduled appointment, you will be charged a $30 fee. This fee will appear on your billing statement.

Our nurses attempt to return patient calls on the same day received. However, because of the high volume of calls that we receive, any calls after 3:00 pm will be returned the NEXT business day. _____

Please allow 48 hours for forms to be completed. _____

Please do not call our physicians after hours to request a prescription refill. They do not have availability to your child's record at that time and are reluctant to fill prescriptions without necessary information. Allow 24 hours for refills to be called in to your pharmacy. Because of insurance requirements, please allow up to 48 hours for a prior authorization (PA) to be completed and faxed to your pharmacy. _____

In the event of bad weather, our office may be closed. Please call the office before coming on days when bad weather is predicted. _____