

PLEASE PRINT CLEARLY

2021

Avon Pediatrics

Patient Information

ADULT -18 years or older

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  M  F

Email: \_\_\_\_\_

Race:  American Indian  Asian/Pacific  Black  White  Multi-racial  Other Hispanic:  Yes  No

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ (home or cell) Alternate Phone: \_\_\_\_\_ (home/cell)

Permission to leave a voice mail? Yes / No

**\*Courtesy appointment reminders will be a call one day prior. Please call us if your phone number changes.**

Insurance Information:

*The office must have completed information below and a scanned copy of the insurance card to file claims. Please let the front desk know if you have more than 2 carriers.*

<u>Primary</u>	<u>Secondary</u>
Policy Holder Name: _____	_____
Relationship to Patient: _____	_____
Policy Holder DOB: _____	_____
Social Security #: _____	_____
Employer Name: _____	_____
Insurance Co Name: _____	_____
Insurance ID: _____	_____
Insurance Group#: _____	_____

Emergency Contact Name #1: \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

Emergency Contact Name #2: \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_


**PLEASE CONTINUE TO NEXT PAGE**

**Consent To Treat:** I give Avon Pediatrics consent to provide and perform medical care, tests, procedures, and administer medications and vaccines considered necessary or beneficial for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

**Consent to Review Medical History:** I hereby give Avon Pediatrics permission to run an Inspect Report through Prescription Monitoring Program to verify the medications that my child has been prescribed. I understand that this information may be stored in his/her confidential medical record.


**Consent to photograph:** I hereby consent to have a photo taken to confirm my child's identity as a patient who will receive treatment from provider, I understand that the photographic image will be stored in his/her confidential medical record.

**Good faith Estimate:** Please let us know if you would like an estimate of the amount you will be charged for a nonemergency medical service in our office.

 Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_


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**FINANCIAL RESPONSIBILITY & FINANCIAL CONSENT: PLEASE READ CAREFULLY:** By signing below, I confirm that all personal information is correct and I verify that I have provided the most current/accurate insurance information for my child. I authorize the release of any information regarding my child's exam and treatment for the purpose of obtaining insurance compensation, precertification or medical records. I authorize payment of medical benefits for services rendered by the physicians at Avon Pediatrics. I acknowledge I have read and understand the Insurance Information /Financial Responsibility and Financial Policy for Avon Pediatrics. I understand a personal copy is available to me at any time upon my request, available online at [www.avonpediatrics.com](http://www.avonpediatrics.com), and posted in the office. In addition, in the event Avon Pediatrics has to pursue a collection action against me, I understand that in addition to my financial responsibility for the medical services provided, I will be responsible for all cost of collection including but not limited to interest charges allowed at the current legal rate, attorney fees and court costs.

 Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Acknowledgement of Receipt of Notice of Privacy Practices– I have read and understand the Notice of Privacy Practices. I understand a personal copy is available to me at any time upon my request, available online at [www.avonpediatrics.com](http://www.avonpediatrics.com), and located in the office.**

 Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Dismissal Policy:**

1. Any new patient who fails to keep their "New Patient" appointment is cause for dismissal at the discretion of the practice.
2. Any established patient who fails 3 appointments is cause for dismissal. This will include all siblings.
3. Any patient/parent who is non-compliant with advice or medications is cause for dismissal at the doctor's discretion.
4. Any patient/parent who fails to meet their financial obligation is cause for dismissal.
5. Any patient/parent who behaves in an abusive or threatening manner, either verbal or physical, will be dismissed.

**Our primary goal is to provide the best possible, most personal medical care we can. We will not discriminate against any patients, but we must maintain continuity of office policies for all patients.**

**If you have any questions regarding any of these policies, please contact our office manager, Rayna N.**

 Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_