Complete Care For Kids

TODAY'S DATE: _____

PATIENT INFORMATION

PATIENT NAMES	DATE OF BIRTH	AGE	SEX:M/F

HOME ADDRESS _____ APT# _____
CITY _____ STATE _____ ZIP CODE _____
PARENT #1 NAME _____ PARENT #2 NAME _____
PARENT #1 SSN: _____ DOB: _____ PARENT #2 SSN: _____ DOB: _____
PARENT #1 MOBILE _____ PARENT #2 MOBILE _____
PRIMARY EMAIL ADDRESS: _____
REMINDER TEXT TO WHICH PHONE NUMBER? _____
BILLING ADDRESS **(if different than above):** _____
PHARMACY NAME _____ LOCATION _____

PRIMARY INSURANCE
INSURANCE COMPANY _____
ID/POLICY NUMBER _____ GROUP# _____
INSURANCE ADDRESS _____
SUBSCRIBER'S NAME _____ SEX ____ DATE OF BIRTH _____
SUBSCRIBER'S SSN# ____-____-____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE
INSURANCE COMPANY _____
ID/POLICY NUMBER _____ GROUP# _____
INSURANCE ADDRESS _____
SUBSCRIBER'S NAME _____ SEX ____ DATE OF BIRTH _____
SUBSCRIBER'S SSN# ____-____-____ RELATIONSHIP TO PATIENT _____

Photo ID & Insurance Card

I acknowledge that at the time of each visit, I am responsible for providing my photo ID and insurance card. **(If a PCP is required by your insurance company you must contact your insurance company and select one of the physicians with Complete Care for Kids prior to the date of service.)**

_____
Initial Here

Late & Missed Appointment Policy

If you must cancel an appointment, please give us at least 24 hours' notice or you will be subject to a $50 missed appointment fee for well visits and consultations (including ADD/ADHD, behavioral,Lactation, and other extended appointments.) Three missed appointments may result in being discharged from the practice.

_____
Initial Here

Health Assessment & School Forms

I understand that when requesting completion of school/daycare forms from Complete Care for Kids, it is my responsibility to provide an annual $30.00 form fee, when forms are presented and/or prior to completion. The forms will not be completed until payment is made.
Please provide an addressed, stamped envelope if requesting forms to be mailed home.

_____
Initial Here

LIKE US ON FACEBOOK! WWW.FACEBOOK.COM/CC4KIDS

(SEE BACK SIDE)

Payment Authorization Policy/HIPAA Acknowledgement

I, _____, hereby authorize Complete Care for Kids, LLC to obtain benefits on my behalf for covered services rendered. I request from _____ insurance company that payments be made directly to the above-named provider. I understand and agree that, regardless of my insurance status, I am ultimately responsible for any balance on my child/children's account and that co-payment must be made at the time services are rendered, if applicable. By federal law and Managed Care Contract Law, this office is required to collect copays at the time of service. Payments are accepted in the forms of check or credit/debit card. There is a $25 returned check fee. If collection becomes necessary, I agree to pay the costs and interest charged including court and attorney's fees.

I certify that all of the information (insurance and demographics) provided is true and correct. I understand that it is my responsibility to notify the office of any changes in my child/children's insurance status. Furthermore, I understand that failure to provide true and correct information could result in my child/children's appointment being rescheduled. I further authorize the release of any information, including medical, for this or any related claim to the above-named billing agent, and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or Complete Care for Kids, LLC at any time in writing.

_____

Guardian Signature/Date

Treatment Authorization

Authorization is hereby granted for my child/children on page one:

To have an examination, immunizations or routine screening procedures as recommended by Complete Care for Kids. This authorization shall be continuous until revoked by you, parents or guardians. I also authorize Complete Care for Kids to initiate any medical treatment required in an emergency.

_____

Initial Here

Vaccination Policy

All patients in the practice are henceforth required to adhere to the vaccination schedule determined by the American Academy of Pediatrics and the Centers for Disease Control or comply with the "catch up" schedule as determined by the Centers for Disease Control. If you feel you cannot comply with this policy, we will ask you to find another health care provider who shares your views.

Excludes the optional vaccines, such as; HPV, influenza and COVID-19

_____

Initial Here

By signing below, I understand and agree with the above-mentioned policies.

_____

Signature Parent/Guardian Name Date

Use and Disclosure of Personal Health Information Agreement:

PATIENT NAME(S):

1. _____ 2. _____ 3. _____ 4. _____

This disclosure contains information regarding the privacy of your child's personal healthcare information. Please read it carefully before signing. COMPLETE CARE FOR KIDS will not be able to continue treatment if you do not sign this disclosure. By signing this disclosure, I acknowledge and agree that COMPLETE CARE FOR KIDS may use or disclose my child's medical information for treatment or obtaining payment for services rendered. I am aware that COMPLETE CARE FOR KIDS may disclose my medical information to a Business Associate for the same reasons, and that the Business Associate will be bound by all appropriate legal restrictions. Further, by signing this document I acknowledge that I have been provided a copy of and have read the Notice of Privacy Practices containing a complete description of my rights and the permitted uses and disclosures under HIPAA. Also, the Federal Government now restricts COMPLETE CARE FOR KIDS from discussing the health information and condition of your child with other family members or persons, unless you specifically give your written permission.

By my signature below, I grant COMPLETE CARE FOR KIDS permission to discuss my child's protected medical information with the following individuals:

1._____ 2. _____ 3. _____

I HAVE READ AND UNDERSTAND THE PATIENTS RIGHTS AND PRIVACY PRACTICES FORMS. YES NO

I CONSENT TO LEAVING NORMAL LAB RESULTS ON MY VOICEMAIL. YES NO

_____

Signature Parent/Guardian Name Date