

# Demographic Information

## Patient Information:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Preferred Name \_\_\_\_\_ AKA \_\_\_\_\_

Date of Birth \_\_\_\_\_ Time of Birth (Newborns only) \_\_\_\_:\_\_\_\_AM/PM Sex: M / F

Primary Language \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

Mailing Address \_\_\_\_\_ Home Address (if different) \_\_\_\_\_

Zip Code \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Email Address \_\_\_\_\_ *(this will give you access to your child's chart)*

Preferred Communications: Mail \_\_\_\_ Home phone \_\_\_\_ Cell phone \_\_\_\_ Email \_\_\_\_ Patient Portal \_\_\_\_

## Associated Party/Responsible Party Information:

Mother's Name \_\_\_\_\_ Mother's Date of birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Preferred Telephone Number \_\_\_\_\_

Father's Name \_\_\_\_\_ Father's Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Preferred Telephone Number \_\_\_\_\_

## Primary Insurance Information:

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Insurance Company \_\_\_\_\_

Patient ID # \_\_\_\_\_ Group ID # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

## Secondary Insurance Information (if applicable):

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Insurance Company \_\_\_\_\_

Patient ID # \_\_\_\_\_ Group ID # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**Preferred Pharmacy** \_\_\_\_\_

## 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.**