

Associates in Pediatrics, S.C.

Patient Information Sheet

Today's Date: _____

First name: _____ Middle initial: _____ Last name: _____ Sex: M F

Date of Birth: _____ E-mail address: _____

Address: _____
ADDRESS CITY STATE ZIP

Primary phone: _____ Secondary phone: _____ Work: _____

Parent _____ Date of Birth _____ Parent _____ Date of Birth _____

Responsible Party Name:

Responsible Party Address: _____
Address City State Zip

Insurance: _____ Who holds insurance policy? _____

Emergency contact: _____ Relationship: _____
NAME PHONE NUMBER

Do we have permission to contact this person regarding matters concerning your care? Yes No

How did you hear about us?-

Ethnicity (check one):

- Non-Hispanic
- Hispanic
- Refused to Report

Primary race (check one):

- White
- Hispanic
- African American/Black
- Asian
- Native American
- Native Hawaiian
- Other Pacific Islander
- Other Race
- Unreported/Refused

Preferred Language (check one): English Spanish Other: _____ Interpreter Needed? Yes No

Preferred Pharmacy #1: _____ Mail Order? Yes No
NAME ADDRESS PHONE NUMBER

Preferred Pharmacy #2: _____ Mail Order? Yes No
NAME ADDRESS PHONE NUMBER

ELECTRONIC PRESCRIPTIONS: Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.

IMMUNIZATIONS: Our electronic medical record program allows for your immunization data to be sent directly to the I-CARE State of Illinois Registry. I-CARE allows your providers to obtain your immunization history to ensure your safety. By signing this, you authorize us to submit this data.

Signature: _____ Date: _____
PATIENT/GUARDIAN RELATIONSHIP TO PATIENT

I have been given a copy of Associates in Pediatrics' Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Associates in Pediatrics has the right to change this Notice at any time. I may obtain a current copy by Contacting the Facility Privacy Official, or by visiting the Associates in Pediatrics website at www.aipdocs.com

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices

Signature or Patient or Guardian Date

Please flip over, and fill out second half

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Our goal is to provide and maintain a good physician–patient relationship. Clear communication helps us achieve that goal. Please review this policy carefully, initial each section, and sign at the end. If you have questions, our staff will be happy to help.

1. ____ (Initial) Missed Appointments

We value the time set aside for your child’s care. If you cannot keep your appointment, please give at least 24 hours’ notice. A \$50.00 No Show/ Late Cancellation fee will be charged for missed appointments, including wellness or physical examinations.

2. ____ (Initial) Insurance Authorization & Responsibility

I authorize Associates in Pediatrics, S.C. (AIP) to release medical information necessary to secure payment from my insurance carrier, Medicaid, or other payers, and to receive direct payment of benefits.

I understand that:

- It is my responsibility to keep my insurance information current. Incorrect or outdated information may result in full patient responsibility for charges.
- I am responsible for knowing my plan’s benefits, including deductibles, copayments, coinsurance, referral requirements, coverage limits, and any services not covered.
- Not all plans cover annual well exams, sports physicals, hearing or vision screenings, or multiple well visits for children under 2 years old.
- If my insurance denies a service as non-covered, I am financially responsible.
- If my insurance has not paid within the contracted time frame, I will be responsible for the balance due.
- In some cases, I may be asked to assist in contacting my insurance company to obtain payment.

3. ____ (Initial) Payment Terms

- Co-pays are due at the time of service.
- Payment may be made by cash, approved check, debit card, MasterCard, Visa, Discover, or AmEx.
- Returned checks will incur a \$35.00 fee.
- Self-pay balances are due at the time of the visit.
- Monthly statements are sent for any remaining balances after insurance has paid. Payment is due upon receipt, even if coverage is in dispute.
- We offer payment plans if needed. Accounts that fail to make agreed-upon payments will be sent to collections.

4. ____ (Initial) Late Fees & Collections

- Balances unpaid after 30 days are subject to a \$25.00 monthly late fee.
- Accounts unpaid for 4 months or more without a payment arrangement will be sent to collections.
- If sent to collections, an additional 35% collection fee will be added to the balance.
- All collection-related costs are the patient/guarantor’s responsibility.

5. ____ (Initial) After-Hours Calls

Telephone calls made to a physician after business hours will result in a \$25.00 fee billed to the patient when the physician returns the call.

6. ____ (Initial) Wellness Coverage

Per the American Medical Association and insurance guidelines, “wellness” includes only:

- Age/gender-specific history and examination
- Risk factor reduction interventions (e.g., vaccines)
- Certain lab tests

Wellness visits do not include evaluation or management of chronic conditions or acute illnesses. These require a separate visit and charge.

7. ____ (Initial) Disputes

(Initial) Any dispute of a balance must be made within 30 days of the date of service or of the insurance company’s final claim adjudication. After 30 days, unpaid balances will be charged to the credit card on file.

8. ____ (Initial) I Privacy Policy

acknowledge that the HIPAA Notice of Privacy Practices has been made available to me by Associates in Pediatrics, S.C.

Patient Name: _____

Responsible Party: _____

Relationship: _____

Signature: _____ **Date:** _____

(OPTIONAL)

Credit Card on File Authorization: _____

Card Number: _____

Authorization Code: _____ (3 digits back / 4 digits front for Amex)

Cardholder Signature _____

Expiration Date: _____