FAMILY INFORMATION

2017

Statement of Nondiscrimination

Centennial Valley Pediatrics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. **Preferred Language: English _____SPA_____OTH_____**

CHILDREN'S NAMES & BIRTH DATES

_____ **M or F** _____
Last Name **First** **Middle** **Birth Date**

_____ **M or F** _____
Last Name **First** **Middle** **Birth Date**

_____ **M or F** _____
Last Name **First** **Middle** **Birth Date**

_____ **M or F** _____
Last Name **First** **Middle** **Birth Date**

GUARDIAN/PERSON RESPONSIBLE FOR PAYMENT

_____ _____
Last Name **First** **Relationship to Patient**

_____ _____
Birth Date **Social Security Number** **Marital Status:** **married** **divorced** **single** **widowed** **partnered**

_____
Home Address **City** **County** **State** **Zip +4**

Which children live @ this address?_____

_____ _____ _____ _____
Home Phone Number **Cell Phone Number** **Work Phone Number** **E-Mail Address**

_____ _____
Employer **Occupation**

OTHER GUARDIAN'S INFORMATION

_____ _____
Last Name **First** **Relationship to Patient**

_____ _____
Birth Date **Social Security Number** **Marital Status:** **married** **divorced** **single** **widowed** **partnered**

_____
Home Address **City** **County** **State** **Zip +4**

Which children live @ this address?_____

_____ _____ _____ _____
Home Phone Number **Cell Phone Number** **Work Phone Number** **E-Mail Address**

_____ _____
Employer **Occupation**

MEDICAL INSURANCE INFORMATION

_____
Insurance Company Name

_____
Insurance Billing Address

_____ _____ _____ _____
Member ID Number **Group Number** **Effective Date** **Subscriber (parent) name**

"I authorize payment of medical benefits to Centennial Valley Pediatrics for professional services rendered $ the release of any medical information necessary to process insurance claims. I also authorize Centennial Valley Pediatrics to give my child/children reasonable & proper medical care by today's standards."

Signature of Patient/Legal Guardian_____ Date_____

PLEASE COMPLETE THE BACK OF THIS FORM

INSURANCE COVERAGE WAIVER

"I understand that my eligibility for coverage by _____(name of insurance company) cannot be confirmed at this time. I wish to receive medical service from Centennial Valley Pediatrics. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Signature of Patient/Legal Guardian_____ Date_____

PRIVACY PRACTICES ACKNOWLEDGMENT

"I have been provided the opportunity to review the Notice of Privacy Practices."

Print you name_____

Signature_____ Date_____

OFFICE POLICY

Payment in full is due a t the time of service unless other arrangements have been made in writing through this office. We are not responsible for filing or collecting your insurance claims unless you are covered by one of our contracted insurances. It is agreed that payments will not be delayed or withheld because of any insurance coverage or pending claims. All proceeds of insurance are assigned to this office when applicable, but without this office assuming responsibility for the collection of the claim. Copayments are due at the time of service.

"I agree to pay, within a timely period, all deductibles & copayments assessed to my account. A monthly rebilling fee is assessed after 30 days. I agree that if it becomes necessary to forward my account to a collection agency, that, in addition to the amount owed, I may also be responsible for costs of collection, including attorney fees.
I certify that I have read, understand and will comply with the above information."

Signature of Guardian_____ Date_____

ACKNOWLEDGMENT OF EMERGENCY CARE PLAN

"I delegate Centennial Valley Pediatrics, or the medical provider(s) they may delegate, to provide any and all medical or surgical care which these children may require in the event that I am unavailable. This will apply only to situations where the delay of that care until such time as I might reasonably be expected to be available would be detrimental to the children. This includes my permission for the children to be admitted to a hospital and the performance of surgery and anesthesia as deemed advisable by the above-mentioned physicians or their delegates.
I hereby authorize Centennial Valley Pediatrics to administer such medications and perform such diagnostic or therapeutic procedures as may be necessary for the prudent medical care of my children."

Signature of Guardian_____ Date_____

EMERGENCY CONTACT (other than parent)

_____ _____
Last Name **First** **Relationship to Patient**

_____
Home Address **City** **State** **Zip**

_____ _____ _____
Home Phone Number **Cell Phone Number** **Work Phone Number**

****Who may we thank for referring you to us?*****

Name _____

Address _____
Street **City** **State** **Zip**