Pediatrics of Steamboat Springs

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Steamboat Location:
Ph. 970-871-1900 Fx. 970-870-3138

Hayden Location
Ph. 970-276-1900 Fx 970-276-7263

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PATIENT INFORMATION:

Patient's Full Legal Name: _____ D.O.B._____ Sex: M F

Address / P.O. Box: _____ City / State /Zip :_____

Patient's Siblings (include last names): _____

Ethnicity: (please circle): Native American Alaskan Inuit Caucasian African Asian Pacific Islander Hispanic Other

PARENT(S) / LEGAL GUARDIAN(S) INFORMATION:

Name: _____ DOB:_____ E-Mail: _____

SSN: _____-___-____Best number to reach you: _____

Name: _____ DOB:_____ E-Mail: _____

SSN: _____-___-____Best number to reach you: _____

Emergency Contact Person other than guardians: _____ Phone #:_____

Cell phone number to be used for **text** appointment reminders: _____

INSURANCE INFORMATION: *PLEASE PROVIDE INSURANCE CARD* - If you do not provide an insurance card, payment in full is expected at time of service, or you may ask to set up a payment plan. Please see our financial policy below.

*Name of Primary Insured on acct: _____ Date of Birth: _____

☐ **NO INSURANCE/SELF PAY:**

PREFERRED PHARMACY

Pharmacy Name: _____ Location: _____ Phone Number (if available): _____

IF VISITING FROM OUT OF TOWN:

Primary Care Physician/Clinic Name: _____ Phone number: _____ Send notes? **Y/ N**

Health Information Privacy Law and Your Rights

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy.

Pediatrics of Steamboat Springs also respects the privacy of our adolescent patients and encourages them to assume responsibility for their own protected health information. Therefore, in addition to a guardian's signature and in accordance with Colorado state law; our practice will require patients thirteen (13) years of age and older to consent to the release of records pertaining to substance abuse (including drug/alcohol abuse), mental health (including psychotherapy notes), contraception and pregnancy, and information regarding sexually transmitted diseases and HIV.

By initialing here, you are attesting that you were offered/received a copy of Pediatrics of Steamboat Notice of Health Information Privacy Practices. _____ **initial here**

ATTENDANCE LATE/NO-SHOW POLICY

At Pediatrics we do our best to ensure the smooth flow of patients in and out of our office. When patients arrive late, cancel at the last minute or fail to keep appointments (no-show) it puts a strain on our schedule and inconveniences subsequent patients who have made an effort to be at their scheduled appointment in a timely fashion.

In an effort to minimize these occurrences it is our policy to send out a friendly reminder to our patients when we notice a pattern of late arrivals, cancellations and/or no-shows. If the problem persists after this letter, Pediatrics reserves the right to assess a $50 no-show fee each time you miss an appointment without 24 hours advance cancellation notice to the office.

Appointment reminders: We provide appointment reminders via email or text, as a courtesy to you. If you want to receive reminders, please be sure to provide your email and cell number above. _____ **initial here to receive reminders.**

******COMPLETE BACK SIDE******

FINANCIAL POLICY

Information Regarding Your Insurance Coverage

We will assist you in billing your insurance company for you. If the insurance company denies your claim, or fails to pay for any reason, the cost for the visit becomes your responsibility. You must be informed of and understand the details of your health insurance coverage and fulfill any associated requirements (i.e. copays and deductibles). It is also your responsibility to provide our office with all required information regarding your health insurance coverage. It is your responsibility to ensure that we have your updated insurance information and mailing/billing address. If any complications arise during the billing process, you have an obligation to promptly provide assistance and information to our billing office and if your failure to timely provide this information or assistance results in a denial of coverage, you will become personally responsible for paying for the services. If you should choose to pay in cash rather than have us bill your insurance, we will take no responsibility for future dealings with your insurance company claims. As a cash patient, that responsibility would fall to you.

Uninsured Patients

If you do not have current health insurance coverage, the entire payment for any services performed shall be paid at the time of service. If payment in full is not possible at the time of service, you will be required to set up an auto drafted monthly payment, for which you will be required to provide us with a routing and account number for your bank or a debit/credit card number. Pediatrics will require you to sign a payment plan agreement at the time of service agreeing to the terms of the payment plan.

Non-Participating Provider or Non Covered Benefits

If we do not participate with your health insurance carrier, or if the services provided are not covered under your particular health insurance plan, then you are responsible for paying for all services at the time of service. If you would like us to do so, we can (upon your request and full payment) provide a statement for your records and/or reimbursement purposes.

Participating Provider and Covered Benefits

If we participate with your health insurance carrier and the services sought are covered services under your particular health insurance plan, then we will directly bill your health insurance carrier. Under your plan, you may be responsible for paying certain amounts (e.g., co-payments, deductibles and fees for non-covered services), which are due at the time of service.

Types of Payment;

Our office accepts cash, Visa, MasterCard, Discover and American Express. We will accept checks at the time of service if your bank responds to our electronic query for "approval." If your financial institution returns a status of "not approved" your check will not be accepted. If your check is returned as uncollectible, we will charge you a $35.00 fee and will no longer accept checks from you.

Collection of Outstanding Balances

All outstanding balances shall be due within 30 days. Unless we have agreed to other payment arrangements in writing, it is important that you pay all past due balances, in their entirety, prior to or at the time of your visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency. If your account is referred to a collection agency, you will be responsible for paying a $50 collection charge, which is in addition to your outstanding balance and any applicable interest. If your account is referred to an outside attorney, you will be responsible for paying all attorney fees and court costs, which are in addition to your outstanding balance and any applicable interest. If your account goes to Collections we will require that all future visits be paid in full prior to your service with cash or credit card.

By signing below, the responsible party acknowledges that he or she has read and understood the foregoing Privacy Policy and Financial Policy and agrees to be bound by the terms and conditions set forth therein. You are entitled to your own copy of these documents and may obtain one from the front desk by request.

Parent/Guardian name: (Please print) _____ **Date:** _____

Parent/Guardian signature: _____