PLEASE PRINT CLEARLY

2018

Doctor: _____

Adult Patient Information ***required information**

* Name: _____* Date of Birth:_____ *SS# _____

***Gender**: ☐ M ☐ F * **Race**: ☐ White ☐ African American ☐ Asian ☐ Multi – Racial ☐ Other **Hispanic**: ☐ Yes ☐ No

*Address: _____City:_____State:_____Zip:_____

*Patient Primary Phone: (___)_____ (home/cell) Alternate Phone: (____)_____ (home/cell)
May leave messages at: **Pt. / Alt. / Both** Appointment Reminders will be made to **Primary Phone number**.

E-mail Address: _____

Note: by providing my e-mail address, I understand that I will receive e-mail newsletters announcing important updates.

Parents' Information:

*Mother: _____*SS#:_____ Date of Birth: _____

Mother's Maiden Name:_____

Address (if different from Patient): _____

*Phone: _____ Employment: _____ Work #:_____

*Father: _____*SS#:_____Date of Birth: _____

Address (if different from Patient): _____

*Phone: _____ Employment: _____ Work #:_____

For additional or extended family members please use reverse side (grandparent, step—parents, etc.)

Release of Protected Health Care Information:

I give consent and authorization for the medical, or billing staff of Carmel Pediatrics to discuss my protected Health Care information with the following person(s): [Parents, grandparents, etc. **PLEASE WRITE FULL, LEGAL NAME OF EACH INDIVIDUAL.**]

_____

_____

SIGN HERE Signature (Patient) _____Date_____

Insurance Information:

In order to file insurance claims, we must have complete information below and a scanned copy of the insurance card(s).

***Primary Insurance Co.:_____ ID #:_____Group #:_____**

Insurance P.O. Box (on back of card):_____ Payor ID (EDI): _____ Ins Phone #:_____

Effective Date of Insurance: _____

Who carries the Insurance? (Subscriber) ☐ Patient ☐ Father ☐ Mother ☐ Other_____

Who is responsible for payment of all unpaid balances on this account? (Guarantor) ☐ Patient ☐ Father ☐ Mother ☐ Other _____

Is there a Secondary insurance? Yes/No

Secondary Insurance Co.:_____ ID #:_____Group #:_____

Effective Date of Insurance: _____

Who carries the Insurance? (Subscriber) ☐ Father ☐ Mother ☐ Other _____

PLEASE CONTINUE TO THE OTHER SIDE

Consent To Treat

I give the physicians of Carmel Pediatrics, LLC consent to provide and perform medical care, tests, procedures, and administer medications and vaccines as are considered necessary or beneficial for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

SIGN HERE Signature (Patient)_____Date_____

Electronic Communications

Automated Calls: As an added convenience, we *may* offer automated reminders via a text message or an automated call for those who wish to participate. The reminders are sent from a computer and cannot be used as a way for you to communicate back to us. If you should need to reach us, please call our main number. If at any time you should change your mind, please let us know what other method you would prefer for reminders.

I understand under the telephone consumer protection act, that in order for you to contact me by automated means for services relating to my medical care, including monies I may owe, etc., I agree that Carmel Pediatrics, LLC and/or your agents may contact me by my cell phone, which may result in charges tome. You may also contact me by text messages, or e-mails providing that I have consented above. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device, as applicable.

□ Yes, I want to participate. My cell phone number is: _____

□ No, I do not wish to participate at this time.

SIGN HERE Patient Signature: _____ Date: _____

Financial Responsibility:

I have verified that all personal information is correct as you have it in my chart. I have verified that the insurance information you have is current. I understand that I could be responsible for payment in full for all services and/or for a $25 fee to re-file to the correct insurance company if I have failed to provide current information and the medical claim is denied by insurance. Any past due balances may result in a $20 service charge and/or a $25 administrative fee to send your account to an outside collection's agency.

I authorize the release of any information acquired during my exam and treatment to be sent to my insurance company for payment of any claims, and authorize payment of medical benefits for services rendered by Randall D. Stoesz, M.D., Susan L. Davis, M.D. , Carolyn O. Robinson, M.D., Anna G. Gilley, M.D., and Elizabeth J. Beach, M.D.

SIGN HERE **I acknowledge that I have read and understand the Financial Payment Policy for Carmel Pediatrics and have been offered a copy:**

***Signature (Patient)_____Date_____** **Signature (Patient)_____Date_____**

_____ _____

_____ _____

_____ _____

Additional Family members/ contact information:

_____

_____

_____

_____

For Office Use Only: _____ Entered by:_____