PLEASE PRINT CLEARLY Doctor: _____

Patient Information

Name: _____ Date of Birth: _____ Gender: ☐M ☐F

Race: ☐White ☐African-American ☐Asian ☐Multi-racial ☐Other Hispanic: ☐ Yes ☐ No

Address: _____City_____State____Zip_____

Primary Phone: (_____)_____-_____(home/cell) Alternate Phone: (_____)_____-_____(home/cell)

May Leave Messages at: **Primary/Alt/Both** Appointment Reminders will be made to **Primary Phone number**.

E-mail Address: _____

Parent's Information

Mother: _____ _____ S.S.#(required)_____ Date of Birth: _____

Mother's Maiden Name:_____

Address (if different from Patient):_____

Phone_____ Employment_____Work#_____

*Father:*_____ S.S.#(required)_____Date of Birth: _____

Address (if different from Patient) _____

Phone_____Employment_____Work#_____

Parents Married? Yes/No If divorced, who has legal custody?_____ *(Please provide legal documentation)*

Siblings:

Name_____ Date of Birth_____ Name_____ Date of Birth_____

Name_____ Date of Birth_____ Name_____ Date of Birth_____

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 _____ID#_____Group#_____

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

Effective Date of Insurance?_____

Who Carries the Insurance (Subscriber)? □ Father □ Mother □ Other _____

Who is Responsible for payment of unpaid balances on this account (Guarantor)? □ Father □ Mother

Do you have Secondary Insurance? □ Yes □ No

Secondary Insurance _____ID#_____Group#_____

Effective Date of Insurance?_____

Subscriber for Secondary? □ 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 child's 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 Parent Signature: _____ Date: _____

Authorization to consent for Medical Treatment in my absence:

I hereby grant the following person(s) the authority to bring my child to Carmel Pediatrics for medical care, tests, procedures, and immunizations.

_____ _____

_____ _____

SIGN HERE Parent Signature: _____ Date: _____

Effective for calendar year 2017.

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 to me. You may also contact me by text messages, or e-mails, providing that I have consented below. 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: _____

My e-mail address is: _____

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

SIGN HERE Parent Signature: _____ Date: _____

Release of Protected Health Care Information:

{Unless otherwise stated only the Mother and Father may receive protected health care information.}

I give consent and authorization for the medical, or billing staff of Carmel Pediatrics to discuss protected Health Care Information about my child with the following person(s):

Name Relationship Phone

_____

_____

_____

FINANCIAL RESPONSIBILTY: PLEASE READ CAREFULLY!

By signing below, I confirm that all personal information is correct, and I verify that I have provided the most current/accurate insurance information for my child. If I have failed to provide current information and the medical claim is denied, I understand that I could be responsible for payment in full for all services and/or for a $25.00 fee to re-file to the correct insurance company. I acknowledge that I have read and understand the Financial Payment Policy for Carmel Pediatrics and have been offered a copy. I understand that if I do not pay my balance in a timely manner, I may be subject to a collections filing fee of $25.00. I authorize the release of any information regarding my child's exam and treatment for the purpose of obtaining insurance compensation, precertification or medical records. I 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 Parent Signature Date Parent Signature Date

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

1/2017 For Office Use Only :_____ Entered by: _____