

PLEASE PRINT CLEARLY

2019

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: \_\_\_\_\_

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

**Parent's Information**

Parent #1: \_\_\_\_\_ S.S.#(required) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent #1's Maiden Name: \_\_\_\_\_

Address (if different from Patient): \_\_\_\_\_

Phone \_\_\_\_\_ Employment \_\_\_\_\_ Work# \_\_\_\_\_

Parent #2: \_\_\_\_\_ S.S.#(required) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent #2's Maiden Name: \_\_\_\_\_

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.

 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.

\_\_\_\_\_  
\_\_\_\_\_

 Parent Signature: \_\_\_\_\_ 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 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.

 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 RESPONSIBILITY: 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 and/or \$20 finance charge. 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.

 Parent Signature	Date	Parent Signature	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____