

E-Mail Address: _____ How did you hear about our practice? _____

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Mailing Address _____ City/St _____ Zip _____

Birth Date _____ Boy _____ Girl _____ Primary # to call for appointment reminders # (____) _____

A COPY OF YOUR INSURANCE CARD IS REQUIRED, AND ALL INFORMATION ON THIS FORM MUST BE COMPLETED.

PRIMARY INSURANCE (MUST BE FILLED OUT COMPLETELY)

Subscriber's Name _____ Mailing Address _____

City/St _____ Zip _____ Birth Date _____ Relationship to Patient _____

Social Security # _____ Employer _____ Ins. Member ID# _____

Group # _____ Name of Insurance _____

SECONDARY INSURANCE (Write none, if applies)

Subscriber's Name _____ Mailing Address _____

City/St _____ Zip _____ Birth Date _____ Relationship to Patient _____

Social Security # _____ Employer _____ Ins. Member ID# _____

Group # _____ Name of Insurance _____

This section below MUST be completed to include: contact information for both parents.

<p>Check one: __Parent __Step-Parent</p> <p>Father's Name _____</p> <p>SS # _____ Birth Date _____</p> <p>Primary # (____) _____ Work # (____) _____</p> <p>Home # (____) _____ Cell # (____) _____</p> <p>Complete, if address is different than child's listed above:</p> <p>Mailing Address _____</p> <p>City _____ St _____ Zip _____</p>	<p>Check one: __Parent __Step-Parent</p> <p>Mother's Name _____</p> <p>SS # _____ Birth Date _____</p> <p>Primary # (____) _____ Work # (____) _____</p> <p>Home # (____) _____ Cell # (____) _____</p> <p>Complete, if address is different than child's listed above:</p> <p>Mailing Address _____</p> <p>City _____ St _____ Zip _____</p>
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- I understand that, even though I may have some type of insurance and authorize this office to submit charges on behalf of my child, I am also responsible for payment. I hereby assign to the doctor, all payments for medical services rendered to my dependent. I am aware **that co payment is required at each visit**, and if there is no insurance coverage, **payment in full** is required for services provided unless prior payment arrangements have been discussed. **I will also be responsible for all collection fees, should my account be assigned to a Collection Agency.**

Signature _____ Date _____

Patient Name: _____

Date of Birth: _____

HIPAA - ACKNOWLEDGEMENT OF RECEIPT

I have been given the opportunity to read and receive a copy of Treehouse Pediatrics' Notice of Privacy Policy.

Signature

Date

I understand that Treehouse Pediatrics will only use and/or disclose PHI (protected health information) for treatment, payment or healthcare operations.

Signature

Date

Patient: _____ Date of Birth: _____

OFFICE POLICY – Please Read Carefully

- Copayment is due at the time of service unless prior arrangements are made. We accept Cash, Personal Check, MasterCard and Visa. **If copayments are not paid, a \$15.00 service fee will be charged.**
- **It is your responsibility to know your insurance benefits. Some vaccines and/or procedures could be subject to deductible, or denied for coverage. You will be held responsible for any charges denied.**
- Any balances that are applied to your deductible must be paid in full before the next office visit. Delinquent accounts will be referred to collections, and discharged from the practice.
- **There is a \$13.00 fee for any after hour phone call to the doctor or triage center. This fee is waived if it becomes necessary to go to the Urgent Care or Emergency Room.**
- **24 hr notice of appointment cancellation is required. Multiple no shows will be subject to dismissal.**
- **We do not take any new Medicaid patients,** although temporary exceptions may be made for existing patients. Please ask to speak with the Office Manager.

Please sign here that you have read this office policy and agree to it.

Parent or Legal Guardian

Date

CONSENT FOR TREATMENT

I hereby authorize evaluation and treatment by the physicians and staff associated with Treehouse Pediatrics. I understand and agree that the signatures and dates on this form will not expire without written notice or in the case that a minor becomes the age of 18, and that a photocopy of this form is considered valid as the original.

Parent or Legal Guardian

Date

CONSENT TO TREAT – WITHOUT PARENT PRESENT

I hereby authorize (name/relationship) _____ to bring my child _____ to his/her appointments if I am unable to attend. I understand that medical advice will be relayed to them on my behalf.

Parent or Legal Guardian

Date