Lakeside Youth N Kids Pediatrics

PATIENT INFORMATION **PLEASE PRINT**

Preferred Phone # to call you _____ Today's Date: _____

Patient Name:_____ Sex: _____ Birthdate: _____

Email address (parent): _____

Race (please circle one): *American Indian* Alaska Native *Asian* Native Hawaiian or Other Pacific *Black or African American* White *Hispanic or Latino* Other Race *Refuse to Report*

Insurance: _____ Subscriber Name:_____ ID#:_____ Group#: _____

How did you hear about our practice? _____

If this is for a child 19 years old or younger, please circle the appropriate answer:

Is the child enrolled in Medicaid? Yes or No Does the child have health insurance? Yes or No
Is the child an American Indian or Alaskan native? Yes or No

ACCOUNT INFORMATION

Patient/Parent/Guarantor _____Sex _____ Birthdate:_____ SSN:_____

Home Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Marital Status: _____

Employer: _____ Work#: _____ Cell Phone: _____

Second Parent/Spouse:_____ Sex _____ Birthdate:_____ SSN: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Marital Status: _____

Employer: _____ Work#: _____ Cell Phone: _____

Others in the family that we need to update: _____

PHARMACY you use & address: _____

What is your language of choice? _____

EMERGENCY CONTACT INFORMATION ***(Not living in the same household)***

Contact: _____ Relationship to patient: _____

Work/Cell Phone: _____ Home Phone: _____

I authorize Lakeside Youth N Kids Pediatrics to give my child or myself reasonable and proper medical care. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to Lakeside Youth N Kids Pediatrics, with the signature below on file in place of the original on submitted insurance claims. I have read, understand and agree to the practice policies.

My signature is also acceptance of all policies of the office.

_____ _____
Signature of Patient, Parent or Guardian Today's Date

Lakeside Youth N Kids Pediatrics

PRACTICE POLICIES

1. Our office will file claims with primary insurance carriers with whom we have contracts; *however the guarantor is responsible for all fees*, regardless of insurance coverage. (**We will not be responsible for submitting to secondary insurance carriers.)**
2. Insurance cards are required to bill. *If we don't have an insurance card you will be considered self pay, therefore non-emergency appointments must be rescheduled or the full amount due must be paid at the time of completed services.*
3. **It is the insured's responsibility to know your health plan and its benefits; some plans do not cover routine or well child exams, immunizations, vision screening, developmental screening, teen screens, that we use in accordance with AAP guidelines. It is also your responsibility to list the correct primary care provider (PCP) on your insurance plan.**
4. **Co-payments or coinsurance, deductibles and payments for non-covered services are required at the time of service, per insurance regulations. A $20 fee could be assessed if your co-pay is not collected at the time of the appointment.**
5. *If we find that you do have a high deductible plan, **please be prepared to pay your portion toward the deductible** at the time of your appointment.* ***We do not make payment plans.***
6. Charges denied for any reason by the EXPLANATION OF BENEFITS of your insurance company are due upon receipt. *If you are not in agreement with your insurance company, you must pay for the services rendered and wait for reimbursement from your insurance company*. We will be glad to resubmit the claim for you or help you if we can.
7. We accept cash, checks, Visa, MasterCard, Discover and American Express.
8. The charge for all returned checks will be at least $20 per check plus any additional charges that the bank charges will be added to the $20 fee.
9. *Any balance over 30 days will be assessed a $5.00 service charge, per month.* This is not covered by your insurance and is your responsibility. ***Well child appointments, physicals and immunizations for the patient and family members cannot be made until all accounts are brought current.***
10. Accounts more than 90 days past due, may be turned over to a collection agency. Any costs or legal fees to recover due services are also the responsibility of the guarantor.
11. Our office will not become involved in any legal agreements between divorced or separated parents, unless legally required to recover due services. *The parent or guardian, who brings the child in, is responsible for the account.*
12. Patients are seen by appointment only, we will try our best to accommodate patients on the same day.
13. Each patient has his or her own appointment. If a brother, sister or parent needs medical attention, a separate appointment (with appropriate co-pay) is required and must be made in advance.
14. We would prefer that we have all previous records before we will schedule an appointment for a physical/well child check.
15. Appointments may be rescheduled at any time, due to emergency or unforeseen events. Our office will try to inform you as soon as possible to avoid causing you any inconvenience.
16. Patients arriving over 5 minutes late for a sick appointment or 10 minutes late for a physical/well child check may be rescheduled for a later time and could be assessed a fee if you do not show up for your appointment.
17. ***A $50 fee could be assessed for no show Well appointments/Physicals and/or ½ hour or longer appointments.*** Your insurance company will not pay for these charges. These charges must be paid before your next scheduled appointment. After 3 no shows, you may be dismissed from the practice.
18. If someone other than a parent or legal guardian needs to bring in a child for a **sick visit**, there must be a written Permission to Treat on file. **There are no exceptions to this policy**. *This cannot be used for Well child physicals –a parent or legal guardian must accompany the child for this type of visit.*
19. School or work excuses will not be written unless the patient has been seen by one of our providers.
20. Prescriptions for antibiotics will not be called in or any other prescription without seeing the patient in the office first.
21. Please allow up to 3 days for medication permission forms to be filled out by your doctor.
22. If the medication is for an Epi Pen, you must also fill out the Allergy & Anaphylaxis Health Care Plan to go with the Epi Pen medication form. (you can find this on our website- lynkpediatrics.com)
23. If the medication is for an asthma medication (ie; inhaler), you must also fill out the Colorado Asthma Action Plan. (you can find this on our website- lynkpediatrics.com)
24. Please allow up to 3 days for school/daycare/sports forms to be filled out by your doctor/provider.
25. Refills for ADD/ADHD medication will not be extended due to missing or forgetting to schedule med check appointments.
26. If you have an appointment for a med check for ADD/ADHD, the Vanderbilt or Acters forms need to be turned into the office at least 3 days prior to the appointment. If these forms are not received, your appointment will be rescheduled until you get the forms completed and turned into the office.

Any deviation of the above policies may be altered or waived only with written approval of Lakeside Youth N Kids Pediatrics.

Lakeside Youth N Kids Pediatrics

Patient Acknowledgement of Receipt of Notice of Privacy Practices
And Consent / Limited Authorization & Release From

You may refuse to sign this acknowledgement & authorization.
In refusing *we may not be allowed* to process your insurance claims or to contact you regarding appointments, results or billing.

Date: _____ Name of patient (**print**): _____ DOB: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices Lakeside Youth N Kids Pediatrics. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR INFORMATION BE SENT TO OTHER PROVIDERS / FACILITYS IN THE FUTURE. **I fully understand that this consent will remain valid until revoked in writing by me.**

Please ***sign*** your name: _____

Legal Representative: _____ Description of Authority: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes parents, step parents, grandparents, spouses, significant others, and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If you need more space please list them on the back of this form

I, _____, give my permission for Lakeside Youth N Kids Pediatrics to leave phone messages and/or text messages regarding my medical care/account information.

How would you prefer to receive ***normal*** test results?

_____ Phone Phone Number: _____

_____ Text Cell Phone: _____

How would you prefer to be informed that test results are available, give appointment reminders or with billing questions and to contact our office for more information?

_____ Phone Phone Number: _____ (Cell / Home / Work – circle one)

_____ Text Cell Phone: _____

If you would like to get on our email list for notifications of changes at the office, flu clinics, special events, etc, please print your email clearly below.

Email: _____

Office Use Only

As Privacy Officer or representative, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because: _____ It was emergency treatment _____ I could not communicate with the patient
_____ The patient refused to sign _____ The patient was unable to sign because _____
_____ Other (please describe) _____

_____ Signature of Privacy Officer or Representative

* Lance J. Lazatin, MD *