**** Please initial and sign the items on the back of this page.****

All Better Pediatrics, PC
2017 Patient Information Sheet

Date: _____
□ New Patient □ Established Patient Update Referred by: _____

Children/Sibling Information

Patient Name (Line 1)	Nickname	Gender	DOB	SSN
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____
4._____	_____	_____	_____	_____

□ **Billing Address**
Father/Legal Guardian
Name_____
Birth date_____
SSN_____
Address_____
City_____ State_____ Zip_____
Phone_____ Cell_____
E-Mail_____

Father's Employer_____
Occupation_____
Work Phone Number _____
Employer Address_____
City_____ State_____ Zip_____

□ **Billing Address**
Mother/Legal Guardian
Name_____
Birth date_____
SSN_____
Address_____
City_____ State_____ Zip_____
Phone_____ Cell_____
E-Mail_____

Mother's Employer_____
Occupation_____
Work Phone Number _____
Employer Address_____
City_____ State_____ Zip____

Emergency Contact _____
Phone_____

Relationship_____
E-Mail_____

Primary Insurance Information
Insurance Carrier _____
Policy Holder's Name_____
Policy Holder's Birth Day _____
Policy Holders ID#_____
Group #/Name _____

Secondary Insurance Information
Insurance Carrier_____
Policy Holder's Name_____
Policy Holder's Birth Day _____
Policy Holders ID#_____
Group#/Name _____

**** Please initial and sign the items on the back of this page.****

(Over)

All Better Pediatrics, PC
Authorizations & Acknowledgments
2017

Date:_____

Assignment of insurance benefits and acceptance of financial responsibility

Initial here:_____ I authorize Pediatric and Adolescent Medicine of East Memphis, PC, D/B/A as All Better Pediatrics, to furnish information to insurance carriers concerning my or my child's illness and treatments, including information about mental health, communicable diseases, and alcohol or substance abuse. I hereby assign to All Better Pediatrics all payments for medical services. I understand that I am responsible for any amount not covered or reimbursed by insurance. If I have paid too much money for these services and have a credit balance, then the extra can be used to offset another bill or account I have with All Better Pediatrics. Credit balances under $100 will be kept on account and offset against future care. Credit balances over $100 will be returned to me within 90 days, if not offset against a balance. Debit and credit balances under $1.00 will be written off. A $35 fee will be assessed for returned checks. A late charge of $6 will be applied to all accounts for each 28-day period past the original statement issued by our office. Interest, at the maximum rate allowed by statute, will be applied to all accounts for each 30-day period past the original statement issued by our office. In the event of non-payment, I agree to pay reasonable attorney fees, court costs, collection agency fees, and all other expenses necessary for collection.

General consent to treatment and tests

Initial here:_____ I am voluntarily seeking medical treatment for myself or my child. I consent to examination by the physician, nurse practitioner, nurse, or other health care professionals at All Better Pediatrics. I also consent to any medical procedures, laboratory tests, or other health care services ordered by the All Better Pediatrics healthcare team.

Acknowledgment of notice of privacy practices (HIPAA)

Initial here:_____ I acknowledge that I have received a copy of All Better Pediatrics' notice of privacy practices.

Authorization to leave messages

Initial here:_____ I authorize All Better Pediatrics to leave messages regarding pending appointments, tests, treatments, bills, or other health issues.

_____Home Phone _____Mobile phone _____Work Phone

No-show policy

Initial here: _____ If I do not cancel a previously scheduled appointment at least 24 hours before the appointment time, then I will be charged a $30 "no-show" fee. I understand that my insurance provider will not pay this fee, so I will be responsible for payment.

Breastfeeding services authorization and policy

Initial here:_____ I acknowledge the following about being treated at All Better Pediatrics for a breastfeeding consultation

1. All Better Pediatrics will bill my insurance for any breastfeeding services that I (Mom) receive.
2. Depending on the nature of those services, my insurance might pay for 100 percent of the allowed amount or I might be liable for a copay and/or deductible.
3. All Better Pediatrics will bill the appropriate insurance for any breastfeeding services that are provided to my child.
4. In instances where All Better Pediatrics bills breastfeeding services for the child, any coinsurance or deductible will be due.
5. At some visits, All Better Pediatrics might bill for both the mother and the child, depending on the situation and to the person to whom services are provided.

_____ _____

Signature of parent/guardian/responsible party | Signature of parent/guardian/responsible party

Name (print): _____ Name (print): _____