MountainView Pediatrics, PC

Demographics

Patient Information: Please list all children

1. Last_____ First_____ MI_____
   Sex_____DOB_____/_____/_____ SSN_____-_____-_____Preferred Name_____
   Race_____Language_____
   (Please circle one) Ethnicity: Declined • Hispanic or Latino • Not Hispanic or Latino

2. Last_____ First_____ MI_____
   Sex_____DOB_____/_____/_____ SSN_____-_____-_____ Preferred Name_____
   Race_____Language_____
   (Please circle one) Ethnicity: Declined • Hispanic or Latino • Not Hispanic or Latino

3. Last_____ First_____ MI_____
   Sex_____ DOB_____/_____/_____ SSN_____-_____-_____ Preferred Name_____
   Race_____Language_____
   (Please circle one) Ethnicity: Declined • Hispanic or Latino • Not Hispanic or Latino

4. Last_____ First_____ MI_____
   Sex_____DOB_____/_____/_____ SSN_____-_____-_____ Preferred Name_____
   Race_____Language_____
   (Please circle one) Ethnicity: Declined • Hispanic or Latino • Not Hispanic or Latino

Responsible Party: Are you the Parent/Guardian? (Please circle one)

Name _____DOB_____SSN_____-_____-_____
Mailing Address_____City, State, Zip_____
Physical Address_____City, State, Zip_____
Home Phone_____Work_____Cell_____
Employer _____
E-Mail Address_____ OK to contact via email? Yes/No
OK to call work? Yes/ No • OK to leave message at work? Yes/No • At home? Yes/No
OK to contact via text? Yes/No
Preferred Contact Method: Phone/Mail/Email Pharmacy of Choice_____

Alternate Contact_____ Phone #_____
Please list someone OTHER than yourself or your spouse that we may contact if we cannot get in touch with you.

Text/Email Preferences
Would you like to receive appointment reminders by text message?
Yes No Already Signed Up If yes, text **mvp** to 622622
Would you like to receive your bill electronically?
Yes No Already Signed Up Email Address: _____

Signature _____ **Relationship** _____
Printed Name _____
Date_____/_____/_____
Revised: 6/10/15

MountainView Pediatrics, PC

Permission List

Patient Information: Please list all children

1. Name: _____ DOB ____/____/____
2. Name: _____ DOB ____/____/____
3. Name: _____ DOB ____/____/____
4. Name: _____ DOB ____/____/____

Permission List

I hereby authorize Mountain View Pediatrics, P.C. to release, disclose and discuss any or all information regarding the patient's office visits, diagnoses, account, and/or any medical care to the following individuals. This also allows the individuals listed below to bring the patient to be seen and treated by the staff of Mountain View Pediatrics, P.C. without myself being present. **(Please list Mother, Father, Step-Parents or any other individual who may need access to the patient's medical information and / or may need to bring the patient to the doctor. Individuals listed below must be 18 years of age or older.)**

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____
4. _____ Relationship _____
5. _____ Relationship _____
6. _____ Relationship _____

I understand that this authorization is valid for a lifetime unless otherwise revoked in writing.

Signature _____ **Relationship** _____

Printed Name _____

Date _____/_____/_____

Revised: 6/10/15

MountainView PEDIATRICS PC

Financial Policy

Co-Pay's are required to be paid at each Office Visit This is part of the contract that you & our clinic have with your insurance company. There is a $5 invoicing fee for co-pays that are not paid on the same date of service.

Deductible Amts / Co-Insurance amounts are asked to be paid at each Office Visit
The amount that we charge you will be the set percentage of charges or, if you have not met your deductible, up to the deductible listed in your contract with your insurance company.

It is your responsibility to pay any co-pay, co-insurance and / or deductibles at each office visit even if you are currently making monthly payments on a previous account balance. A payment arrangement does not waive payment on any current visit charges.

Well Child Visits
It is your responsibility to know your well coverage, including coverage for vaccines, prior to your visit. You may obtain this information by calling the toll free number on the back of your insurance card.

Patients pending Insurance will be asked to pay the office visit in full on each date of Service.
(Exception will be made for new babies under one month old while they are being added to Insurance Policy.) We will file the Office Visit when we receive your insurance information and will gladly refund your money if your insurance pays or discounts the Office Visit.

Uninsured Patients
As a courtesy to our patients we do offer a prompt pay discount for all charges ***paid in full*** on the date of service. If you are unable to pay in full on the date of service other payment arrangements must be made prior to being seen.

In cases of separation / divorce, we cannot bill the other spouse or parent.

Please understand that payment will be required by anyone bringing in your child regardless of any court order. It is your responsibility to collect from any 3rd party.

If you do not follow this Financial Policy we will be forced to send your account to a Collection Agency and we will ask that you make other arrangements for the patient's medical care. If your account is sent to a Collection Agency you will be responsible for any collection or attorney fees related to your delinquent account. Please be advised that collections fees can be up to 40% of the account balance.

You agree, in order for us to service your account or to collect any outstanding balances, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that MountainView Pediatrics, P.C. may contact me/us as described above.

I understand that this authorization is valid for a lifetime unless otherwise revoked in writing.

Signature _____ **Relationship** _____ **Date** _____

Revised: 6/10/15

I, the undersigned, hereby consent to and authorize the administration: and performance of all treatments, the administration of any needed anesthetics: the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, the use of prescribed medication: the performance of diagnostic procedures: the taking and utilization of cultures and performance of other medically accepted laboratory test, all of which the judgment of the attending physician or their assigned designees, may be considered medically advisable. I fully understand that this consent is given advance of any specific diagnosis or treatment. I intended this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. **This is a lifetime consent that will remain in full force until revoked in writing.**

I hereby authorize Mountain View Pediatrics, P.C. to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Mountain View Pediatrics, P.C. of benefits otherwise payable to me. I hereby authorize the release of my medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided. I understand that I am financially responsible for charges not covered by the authorization. A photocopy of this authorization shall be considered as valid as the original. Personal health information about the patient may be obtained from previous providers and shared among providers involved in the patients care to promote the delivery of quality, efficient, and economical medical care. This information could be shared electronically, in writing, or verbally.

I understand that this authorization is valid for a lifetime unless otherwise revoked in writing.

I understand that I may revoke this authorization by sending a written notice to Mountain View Pediatrics, P.C. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights of confidentiality. You have the right to speak to an attorney or other counsel prior to signing. We have no control over information once you have authorized its release from our office.

My signature below authorizes MountainView Pediatrics, PC to obtain the medication history from my insurance company.

The parent/guardian signing below is the responsible party.

Signature _____ **Relationship** _____
Printed Name _____
Date _____/_____/_____

Revised: 6/10/15

MountainView
PEDIATRICS PC

Easy Pay Consent Form

This form is optional

I authorize MountainView Pediatrics to maintain my credit/debit card on file for the balance of charges not paid by insurance within 90 days.

Not to exceed $ _____ 0 Annually 0 Monthly 0 Weekly 0 per Visit

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

_____

Cardholder Signature Date

Patient Name (s)_____

Cardholder name _____

Cardholder address _____

City _____ State _____ Zip_____

Card Number _____-_____-_____-_____ Exp Date ____-____

V Code _____

Updated: 2/2014

MountainView PEDIATRICS PC

Authorization to Release Information

(Updated 6/10/15)

Patient Information:

Name: _____ *Date of Birth:* _____

SSN: _____

Records are being requested from:

Facility Name: _____ *Phone Number:* _____

Fax Number: _____

Please send records to:

Facility Name: _____ *Phone Number:* _____

Fax Number: _____

The following information may be released: (Please check one)

____ *Complete Record* ____ *Other: (Please specify)* _____

Purpose for release of records: (Please check one)

____ *Continue Care* ____ *Personal Use* ____ *Other:* _____

Sensitive Information: *I understand that the information in the patient's record may include information relating to sexually transmitted disease, AIDS, or infection with HIV. It may also include information about behavioral or mental health services, alcohol and drug abuse, or physical and mental abuse.*

Right to Revoke: *I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this information.*

I understand that MountainView Pediatrics is not responsible for Medical Records once they have been released from the office.

_____ _____

Signature *Date*

_____

Relationship to Patient

_____ ***This release will expire one year from the date signed.***

Verification

Rachel Rogers, MD
Amy Harden, MD
Jan Marie Gambrell, CPNP
Karen Bordwine, FNP-BC
Tessa Brown, FNP-BC

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