**PATIENT INFORMATION**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex Male/Female

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex Male/Female

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex Male/Female

Race\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity Hispanic/Not Hispanic Patient Email (**over age 13**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home/Cell? Patient Phone (**over age 13**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Provider/Who do you like to see? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

**Guardian’s Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is this person an authorized medical decision maker for the patient? Yes/No

Primary Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home/Cell? Guardian Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (If different from patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­

**Guardian’s Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is this person an authorized medical decision maker for the patient? Yes/No

Primary Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home/Cell? Guardian Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (If different from patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT (NOT LIVING IN HOME) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_PHONE NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE INFORMATION**

**\*\*\*In order for us to submit claims to your insurance company, we do NEED this form completed in its entirety. \*\*\***

**Primary Insurance** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address (If different from patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Effective Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_

Subscriber’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address (If different from patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR TREATMENT:** I (we) give the following people permission to bring our child in for treatment (i.e. grandparent, nanny, etc.)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **INITIALS** \_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **INITIALS** \_\_\_\_\_\_\_\_\_\_\_

**CONSENT FORMS-REQUIRED**

**FINANCIAL POLICY AND CONSENT**

You are responsible for your child’s healthcare costs. It is important to become familiar with your specific insurance plan. If you have questions, please contact your insurance company or employer directly. It is also important to realize that health insurance policies rarely cover all medical costs and that patients are usually responsible for a portion. Health insurance is a contract between you and your insurance company. You are still responsible for any services rendered on your child’s behalf. We realize that many families are in a state of change. Divorced, separated, single parent and blended families are common. In many of these families, the question of who is responsible for the children’s medical bills is uncertain. **Our policy is that the parent who brings in the patient is ultimately responsible for all fees incurred,** unless other arrangements are made with our office in writing. We will bill your insurance company providing we are contracted with them and that you provide us with information at each visit regarding your current plan. Current insurance cards MUST be presented at each visit. Copayments are due on the date services are rendered. All copayments not received on the date of service are subject to an additional fee. Patients without insurance/”self pay” are required to pay in full at the time of service. All balances over 60 days are considered past due and will be handled appropriately. Payment plans are available through our billing office.

1. I understand that payment for charges is due on the date of service with the exception of insurance carriers for which Red Rocks Pediatrics is under contract to file directly.
2. I understand that my insurance coverage may not provide payment for all charges incurred in obtaining treatment from Red Rocks Pediatrics. I will be responsible for any copayment, deductible or services not covered by my insurance provider. If I do not have insurance coverage for services rendered by Red Rocks Pediatrics, I agree to pay all charges resulting from such services.
3. I hereby authorize Red Rocks Pediatrics to file with my insurance carrier, and I assign payment of medical benefits to Red Rocks Pediatrics.
4. I authorize release of any and all medical records and information necessary to process any claim generated by services I receive in this office.
5. I will keep my account current as to charges for which I am responsible. In the event that I fail to pay charges, Red Rocks Pediatrics is entitled to take whatever action necessary to collect such charges, and I will be responsible for reasonable attorney fees and costs incurred as a result of such collection. I understand that those accounts on a payment plan that are not kept current are subject to further action.
6. I understand that Red Rocks Pediatrics, PC is closed to new patients with state-funded insurance including Medicaid. If it is determined that a family member is found to have coverage, I will be assisted in finding a new medical home for my family that is accepting new patients with state insurance.
7. I understand that all missed appointments are subject to a fee not billable to my insurance. A 24-hour advanced notice is required to cancel an appointment unless it is made the same day. Appointments made the same day require a 4-hour cancellation notice.

**CONSENT FOR TREATMENT:** I, the undersigned, voluntarily agree to the tests, procedures and/or treatments which the attending physician has deemed necessary and which is administered to or performed on my child under the direction of the attending physician and his/her designees.

**CONSENT TO PHOTOGRAPH:**  I hereby authorize the use of photograph(s) when indicated for the purpose of medical documentation and treatment as part of my child’s medical record.

**CONSENT TO COPY MEDICAL RECORDS:** I understand that it may be necessary for other healthcare providers to review information in my or my child’s medical record in order to render medical care. I authorize Red Rocks Pediatrics to copy part or all of my medical record in the event that it is needed by another healthcare provider in order to provide medical treatment. Red Rocks Pediatrics endorses, supports, and participates in electronic Health Information Exchange, CORHIO and CIIS, as a means to improve the quality of health and the healthcare experience and reduce costs by eliminating unnecessary duplication of tests, vaccines, and procedures. Notify the office if you wish to opt out of CORHIO or CIIS.

**CONSENT TO ELECTRONIC COMMUNICATION:** I hereby authorize Focus on Kids Pediatrics providers and staff to respond to electronic requests I make. **I understand that electronic communication should not be used for emergent or urgent messages as it is not monitored constantly.** I understand that I need to call the office for appointment requests and urgent medical questions. I understand that electronic communication may not be 100% secure. I understand that it is my responsibility to notify the office with email or phone number changes. All electronic communication becomes part of the medical record. We cannot guarantee that we will respond in a timely manner, and we understand that you cannot guarantee you will respond. For important issues, telephone is best. If you believe you have received a message in error, please notify our office.

**My signature indicates that I have read and agree to all terms set above.**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**

**PHONE MESSAGE CONSENT:** There may be times when a provider or staff may need to contact you with medical information (including but not limited to lab results, referral information and appointment information) via telephone. By filling in the information below, you will be authorizing us to leave medical information on an answering system at the designated number(s). You may also allow us to leave a message regarding medical information with a designated person (i.e. grandparent or daycare provider, etc.) other than the patient, parent, or legal guardian (if the patient is under 18 years of age). I understand that it is my responsibility to notify the office of any changes in my contact information, and this will remain in effect until revoked in writing.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **INITIALS** \_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **INITIALS** \_\_\_\_\_\_\_