Integrative Pediatrics, LLC

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Patient Information Sheet

To ensure accuracy, please complete insurance section, despite scanning of your insurance card. Thank you!

Sex: Patient(s)

M F ____________________ d.o.b ________

M F ____________________ d.o.b ________

M F ____________________ d.o.b. ________

M F ____________________ d.o.b. ________

Insurance Carrier: ______________

Subscriber: ______________________

ID# ______________________

Group # ______________________

Co-pay Amount $____________

Home Address:

____

____

____

Apt #, City, State & Zip

Secondary Insurance?______________________

Subscriber: ______________________

ID# ______________________

Group # ________________

Mother's Name: Please write clearly!

Name: __________________________**Sex** _____**SSN#**_________________________

D.O.B. _________________ **Email Address:** _______________________________

Home # ________________ **Cell #**________________ **Wk #**____________________

Home Address: ____

Father's Name:

Name: __________________________**Sex**_____ **SSN #**________________________

D.O.B. ____________________**Email Address:** ______________________________

Home # _________________ **Cell #**__________________ **Wk#**_______________

Home Address: ____

Referred by: To whom do we thank for your referral?

____

Name **Relation**

3rd Contact: If we are unable to reach you directly

____

Name **Relation** **Phone**

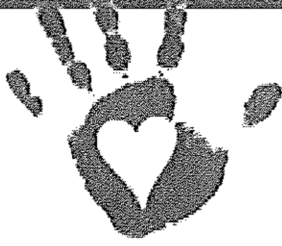
I have filled this out to my best ability and believe this information to be true and accurate. If any of the above information changes; I will notify Integrative Pediatrics LLC in writing.

____

Signature **Date**

____

Print your name



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Financial Policy

Welcome to Integrative Pediatrics LLC. Dr. Thomas is committed to providing the best care possible and appreciates your trust. Please take your time to review the following information and sign and date below.

Integrative Pediatrics LLC will gladly submit claims to your insurance carrier. We also offer Secondary and Tertiary billing. Please remember that co-pays are due at the time of service. If unable to pay at time of service there will be a $10 fee applied to your account for non-payment. In the event of a Motor Vehicle Accident, we will submit your claim(s) to the motor vehicle carrier.

As a courtesy, our Established Private Pay patients receive a cash allowance rate. We accept cash, debit cards, checks, Visa, MasterCard, American Express and Discover. Although payment is required at the time service; if unable to pay; prior arrangements can be made with the billing coordinator. Please call Kristy at 503-643-2100. If your account is paid in full at the time of service, we will extend a prompt payment/cash allowance rate. For Non-Established Private Pay patients a $50.00 deposit is required if unable to pay in full at the time services are rendered.

If you have health insurance, please understand that this is an agreement between you and your insurance company; and you are responsible for knowing your benefits. We will be happy to assist you in any way we can, but *you* are ultimately responsible for timely payment of your account.

Integrative Pediatrics LLC takes many steps to avoid collections; however if your account is placed with a collection agency; you will be assessed a 100.00 collection fee. This will be added to your final balance placed with the collection agency and you will also be responsible for all legal fees and court costs involved.

In the event of a divorce situation; we do understand your difficulties and we hope you understand a divorce decree is a document that involves you, your ex-spouse and the courts. Although a divorce decree may state that an ex-spouse is responsible for medical bills, Integrative Pediatrics LLC has no authority to enforce compliance. Therefore, we will bill the custodial parent.

If you present a check to Integrative Pediatrics LLC that is not honored by your bank, a 20.00 Non Sufficient Funds charge will be added to your account per occurrence.

If you are unable to keep your appointment, please cancel within 3 hours by calling 643-2100. After 3 consecutive No Show appointments or Cancellations (after the appointment has lapsed) you may be terminated from Integrative Pediatrics LLC.

Your signature on this policy authorizes Integrative Pediatrics LLC to release health information to insurance carriers when necessary for payment, and directs them to remit payment directly to Integrative Pediatrics LLC (assignment of benefits).

____

Signature Date

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ACKNOWLEDGMENT AND CONSENT

I understand that Integrative Pediatrics LLC (referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area and *available on the website at* www.integrativepediatricsonline.com

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:______________________________ Date:____________
(Patient- must be 15yrs)

-OR-

By:______________________________ Date:____________
(Patient representative)
Description of Representative's Authority:____________________________

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