HUNTSVILLE PEDIATRIC ASSOCIATES

Patient Information Form

Patient Information

Child's Name ____ Male___ Female ___

(First) (Last)

Preferred Name ______________________________ Child's DOB _______________

Child's Street Address ____

Child's Mailing Address ____

City ___________________________________ State__________ Zip ___________

Home #________________________ Cell # (14yrs & older) _______________________

Ethnic group (please select one): Hispanic ___ Non-Hispanic ___

Race (please select one or more): Asian ___ African American___ Caucasian___ Other ___

Prefer not to answer____

Preferred Language: ____

With whom does the child live? Mom and Dad __ Mom__ Dad__ Other__

Who has legal custody? Mom and Dad __ Mom__ Dad__ Other__

Who is the financially responsible party? Mom and Dad __ Mom__ Dad__ Other__

List all household members and their relationships to the patient:

____

____

____

____

We require court documents regarding custody agreements from all divorced families.

Emergency Contact & Relationship

1.Name ____ Phone #______________________

2. Name ____ Phone #______________________

Parent/Guardian 1 Information

Name____ Male _____ Female ____

(First) (Last)

Relationship to patient (circle one): Mother Father Other: ________________ DOB _________________

Address (if different than patient's) ____

Home #__________________ Cell # __________________ Work #__________________

Email ____

Parent/Guardian 2 Information

Name____ Male _____ Female ____

(First) (Last)

Relationship to patient (circle one): Mother Father Other: ________________ DOB _________________

Address (if different than patient's) ____

Home #__________________ Cell # __________________ Work #__________________

Email ____

Insurance Information (Please give card to the receptionist)

Primary Insurance Company name __________________________________ Copay $___________________

Policy/ID____ Group #___________________

Policy holder's full name ____ DOB_________________________

Policy holder's relationship to patient ________________________________ Effective date ______________

Secondary Insurance Company name __________________________________ Copay $_________________

Policy/ID____ Group #___________________

Policy holder's full name ____ DOB_________________________

Policy holder's relationship to patient ________________________________ Effective date ______________

Huntsville Pediatric Associates

Patient Name ______________________________________ Patient DOB __________________

Non-Covered Services Policy

The physicians of Huntsville Pediatric Associates want to provide your child with the best care possible. Therefore, we follow the recommendations of the American Academy of Pediatrics, the Centers for Disease Control and The Advisory Committee of Immunization Practices. There may be times when immunizations, laboratory tests to include labs sent to an outside facility (Covid tests, genetic screenings, etc.), vision/hearing screenings, telemedicine calls/appointments and forms/authorizations may not be covered under your insurance policy. If this should occur, you will be responsible for payment.

Initial: _____

AUTHORIZATION AND ASSIGNMENT

I, the undersigned, hereby agree to pay all amounts and charges hereafter incurred by me or other members of my family for services rendered at this office. In the event of non-payment, either by insurance or by me, the balance will increase. Collection proceedings will result in permanent dismissal.

I acknowledge and agree that Huntsville Pediatric Associates and any affiliates or vendor including collection or billing companies, may contact me by telephone or text message to any telephone number I have provided, and any other telephone number associated with my account, including mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as Automated Telephone Dialing Systems (ATDS) or prerecorded message. I also agree that I will notify Huntsville Pediatric Associates if I have given up ownership or control of any such telephone number.

Initial: _____

CONSENT FOR TREATMENT

I authorize the doctors of Huntsville Pediatric Associates to treat my minor child listed above as they deem medically necessary. I authorize emergency medical treatment for the above-named child if he/she is brought into this practice by any person other than myself.

Initial: _____

____ _______________________________

Signature of parent or legal guardian Date

____

Print Name

HIPAA

Please print all information.

Patient Name ____ DOB __________________

I authorize Huntsville Pediatric Associates to disclose or provide protected health information about my child to the individual(s) listed below.

Who will be authorized to receive information (the individual(s) to receive your child's PHI):

Name____ Relationship_____________________
Name____ Relationship_____________________
Name____ Relationship_____________________
Name____ Relationship_____________________
Name____ Relationship_____________________
Name____ Relationship_____________________

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about my child/me to the person, or persons identified above:

___entire patient record

OR

___ office notes ___lab results/pathology reports ___x-rays ___financial information

This authorization will expire at the end of the calendar year unless you specify an earlier termination. Please list the date of the expiration if earlier than the calendar year.

____

We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

____ ___________________

Signature of patient if 14yrs or older or legal guardian Date

Huntsville Pediatric Associates

2004 Airport Rd, Suite 1 Huntsville, Al 35801

Phone # 256-888-5437 Fax # 256-705-1156 Email www.huntsvillepediatrics.com

Forms

Fees will be charged for the following forms if not requested at the time of an office visit:

Physical Form $15

Medication Form $15

FMLA Paperwork $30

College Form $30

Express Fee $30

Services

After Hours Phone Call $25

No Show Shot Clinic Appointment $25

Non-Routine Rx $25

Portal Picture $ 25

Holiday/Weekend Fee $30

Work In $35

No Show Appointment $50

Ear Piercing $75