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

Policy for Divorced or Separated Parents

Our highest priority is the care of our patients. We have many patients whose parents are either separated or divorced and we are happy to work with either or both parents to make sure the child's healthcare needs are met.

When a child is seen in our office and accompanied by either parent, we will assume that parent has the authority to make medical decisions for the child, unless we are instructed otherwise by legal documentation.

It is essential that both parents reach an agreement regarding their child's healthcare needs prior to arriving at our office as we will not mediate disagreements. We will discuss our medical assessments and recommendations with the parent who accompanies the child to the office or contacts us by telephone or portal. However, we are happy to answer any questions regarding your child's health from either parent at any time.

Copays will be collected at the time of service by the accompanying parent or guardian, regardless of divorce decree. If the court agreement states otherwise, we will be happy to provide a receipt at the time of the visit for medical reimbursement to be settled privately between parents.

HPA providers and staff will not become involved in disputes between family members. Should a dispute interfere with your child's healthcare, or should an issue become disruptive to our practice, we will discharge the patient from further treatment.

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