Southside Pediatrics, APMC

Patient Info: Male____ Female_____ Date_____

Name: Last_____ First_____ MI_____

DOB _____ SS#_____ **Parent Email:** _____

Mailing Address_____ City/ Zip_____

Primary Phone Number_____ Secondary Number_____

Siblings_____ School/Daycare: _____

Pharmacy_____ Location Phone Number (if available) _____

Race: ____ American Indian or Alaska Native

____ Asian

____ Black or African American

____ Native Hawaiian or other Pacific Islander

____ White

____None of the above

Ethnicity: ____ Hispanic or Latino

____ Not Hispanic or Latino

____ Black or African American

____ None of the above

How would you like to receive appointment reminders? Text _____ or Voice _____

PARENT INFORMATION: RESPONSIBLE PARTY

FATHER

NAME: _____

Last 4 digits of SSN: _____ DOB: _____

Address: _____

City and Zip: _____

Cell phone: _____

Work phone: _____

Employer: _____

MOTHER

NAME: _____

Last 4 digits of SSN: _____ DOB: _____

Address: _____

City and Zip: _____

Cell phone: _____

Work phone: _____

Employer: _____

INSURANCE INFORMATION

Primary: _____

Policy Holder: _____

Relationship to Patient: _____

DOB: _____ SSN: _____

Employer: _____

ID# _____ Group# _____

Secondary (if any): _____

Policy Holder: _____

Relationship to Patient: _____

DOB: _____ SSN: _____

Employer: _____

ID# _____ Group# _____

Appointment Policy

There is a 15-minute grace period for all scheduled appointments. If check in is after the twenty minutes, the appointment will be rescheduled for the next available time. If you fail to call and cancel an appointment there will be a $20.00 non-cancellation fee due before another appointment will be scheduled. If the patient misses three appointments he/she will be dismissed from the practice. You will have 30 days to find another Primary Care Physician.

Copay and Deductible amounts are due before seeing Physician.

Additional Fees and Policies

There will be a $5.00 fee for any forms and letters needed to be filled out by the physician. There will be a $1.00 charge for copies of shot records. Please remember to obtain any school or work excuses needed while at check out. Excuses or shot records will not be faxed or mailed; they will have to be picked from the office.

We accept cash or checks and major credit cards only; please note there will be a $30.00 NSF fee for any checks returned unpaid from your bank. This will have to be paid before another appointment will be scheduled.

Information Sharing and Treatment Consent

I hereby authorize Southside Pediatrics APMC to furnish information to insurance carriers (and doctor's offices) concerning my illness and treatments. This Signature also authorizes you to give me reasonable and proper care by today's standards. I understand that I am responsible for all fees, regardless of my insurance coverage. In order to expedite insurance company payments, the necessary forms will be completed by this office. It is customary to pay for services when rendered unless other arrangements have been made in advance. I will also be responsible for any legal or other costs incurred in the collection of this account. Note: your health information will be kept confidential.

Signature_____DATE_____

Person Other than Parents Allowed Too Consent for treatment/ Bring Patient to Doctor

1. Name_____Relationship_____
2. Name_____Relationship_____
3. Name_____Relationship_____
4. Name_____Relationship_____

Acknowledgement of Receipt of Privacy Notice (HIPPA)

*Name*_____*Relationship*_____

*Signature*_____ *Date*_____

Notice Received? Yes _____ No_____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____