MONCLOVA ROAD PEDIATRICS

Please note: current Insurance card and valid Photo ID is required at each visit

Patient Information (PLEASE PRINT):

DATE: ____________________

LEGAL NAME: ____
(LAST) (FIRST) (MI)

SEX: **MALE** **FEMALE** D.O.B ____________ SSN: ____________________

ADDRESS: ____
(STREET) (CITY) (STATE) (ZIP)

Phone Number to Confirm appointments: (   ) ______________________________

Hospital delivered at: ______________________________ weeks early: __________
NEWBORN PATIENTS

MOTHERS MAIDEN NAME: ____________________ EMAIL ADDRESS: ____________________

LANGUAGE: ENGLISH / SPANISH / RUSSIAN / INDIAN (INCLUDES HINDI) / OTHER

ETHNICITY: HISPANIC OR LATINO / NOT HISPANIC OR LATINO / REFUSE TO REPORT / UNKNOWN

RACE: WHITE / BI-RACIAL / BLACK / ASIAN / PACIFIC ISLANDER / OTHER / UNAVAILABLE

MARITAL STATUS (Patient): SINGLE / MARRIED / DIVORCED / SEPERATED / WIDOWED / UNKOWN

RELIGION: ____

PLEASE LIST (ALL)NAME, AGE, AND RELATIONSHIP OF THOSE AT PRIMARY HOUSEHOLD

(LAST NAME)	(FIRST NAME)	DOB	(RELATIONSHIP)

Name of DayCare / School ____

Phone # ____________________ Fax # ____________________

PATIENT NAME: D.O.B

PARENT/GUARDIAN NAME: D.O.B

RELATIONSHIP TO PATIENT: MOTHER FATHER GRANDPARENT FOSTER PARENT OTHER | FEMALE | MALE

ADDRESS:

If different than patient (STREET) (CITY) (STATE) (ZIP CODE)

Preferred Communication: No Preference Do not contact Mail MyChart Phone:____________________________

MARITIAL STATUS SPOUSE:

EMPLOYER: OCCUPATION:

PARENT/GUARDIAN NAME: D.O.B

RELATIONSHIP TO PATIENT: MOTHER FATHER GRANDPARENT FOSTER PARENT OTHER | FEMALE | MALE

ADDRESS:

If different than patient (STREET) (CITY) (STATE) (ZIP CODE)

Preferred Communication: No Preference Do not contact Mail MyChart Phone:____________________________

MARITIAL STATUS SPOUSE:

EMPLOYER: OCCUPATION:

GUARNTOR (**WHO IS RESPONSIBLE FOR PATIENT'S BILL**)

NAME: DOB:

SS#: PHONE#

ADDRESS:

(STREET) (CITY) (STATE) (ZIP CODE)

PRIMARY INSURANCE:

POLICY HOLDER: ◯ Employer Provided

Name DOB ◯ Market Place

RELATIONSHIP TO PATIENT: SS# ◯ State Provided

SECONDARY INSURANCE:

POLICY HOLDER: ◯ Employer Provided

Name DOB ◯ Market Place

RELATIONSHIP TO PATIENT: SS# ◯ State Provided

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MY INSURANCE CARRIER(S) TO THE PHYSICIAN FOR SERVICES RENDERED WHEN AN ASSIGNED CLAIM IS FILED. **(TO BILL INSURANCE, YOUR SIGNATURE IS REQUIRED)**

X

PATIENT/GUARDIAN SIGNATURE

DATE SIGNED

HIPAA AUTHORIZATION

MONCLOVA ROAD PEDIATRICS

I, ____, a

Natural or Adoptive Parent of ◯

Guardian of ◯

Person, who under court order, is authorized to give consent for (PLEASE PROVIDE COURT PAPERS)

NAME: ________________________________ DOB: ________________

Patients Name **Patients date of Birth**

I authorize Monclova Road Pediatrics to discuss and provide medical treatment of the above named minor with the following authorized adult(s) over the age of 18. (ie: Parents/Guardians, Grandparents, Siblings, Aunts/Uncles, Step-Parents, etc)
CIRCLE ALL THAT APPLY

***PARENT(S) OF MINORS, PLEASE INCLUDE YOURSELF**

Name: ________________________ Phone: ________________ cell/home

Relationship to Minor: ________________ Phone: ________________ cell/home

We may: Leave DETAILED message Leave name/number ONLY Allow for prescription pickups

Name: ________________________ Phone: ________________ cell/home

Relationship to Minor: ________________ Phone: ________________ cell/home

We may: Leave DETAILED message Leave name/number ONLY Allow for prescription pickups

Name: ________________________ Phone: ________________ cell/home

Relationship to Minor: ________________ Phone: ________________ cell/home

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Name: ________________________ Phone: ________________ cell/home

Relationship to Minor: ________________ Phone: ________________ cell/home

We may: Leave DETAILED message Leave name/number ONLY Allow for prescription pickups

X ________________________ ________________

Signature of Parent / Guardian Date Signed (first year)

X ________________________ ________________

Signature of Parent / Guardian Date Signed (second year)

X ________________________ ________________

Signature of Parent / Guardian Date Signed (third year)

MONCLOVA ROAD PEDIATRICS

Patients Name D.O.B

* INSURANCE RESPONSIBILITY NOTICE and CONSENT *

MONCLOVA ROAD PEDIATRICS, Ltd. Will make every effort to assist our patients in understanding the scope of your insurance benefits and the method of determining your coverage. Nevertheless, it is ultimately **your responsibility** to understand your policy, its benefits, and the obligations it places on you. It is **not** the responsibility of Monclova Road Pediatrics, Ltd. to verify your insurance coverage or determine which services are or are not covered. Additionally, it is your responsibility to insure that laboratory tests, vaccines, and consultations are covered by your insurance. Therefore, if your insurance denies payment for any reason, the amount owed is your responsibility and must be paid promptly.

To divorced parents:

It is our office policy that all correspondence, medical and financial, is sent to one address, usually where the child resides. It is up to the parents to decide how best to communicate between households, information and concerns regarding your children. Fees for office visits are due at the time of service. WE will NOT bill separate households for payment. Parents should work out the arrangements between themselves.
REGARDLESS of what your divorce decree states, we ARE NOT part of that settlement.
This is the only way we can provide good medical care for you children.

*Co-Pay Policy *

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
CO-PAYS ARE DUE AT THE TIME OF SERVICE. A $5.00 BILLING FEE WILL BE ADDED IF NOT PAID AT THE TIME OF SERVICE. Collection, as well as Payment of co-pays is part of the contractual agreement both parties agree to when joining an **HMO / PPO** or managed care plan.
WE ACCEPT CASH, CHECK, AND MOST MAJOR CREDIT CARDS
RETURNED CHECKS: There is a $25 administration fee for all returned checks.
Should your account be forwarded to a collection agency, a $50 administration fee will be added, and in, most cases, we will dismiss your children from our practice.

Canceling You Appointment and NO-SHOW Policy

Scheduled appointments are very important, they allow you and your provider to have productive time together, and are, needed in order to provide the highest quality of care possible. A scheduled appointment is maintained so that all our patients who need care can be seen in a timely fashion. When appointments are cancelled, that allows us to offer that time to someone else who may need to be seen. We realize that, at times, circumstances may not allow you to keep your scheduled appointments. We ask that you provide us with a 24 hour advance notice when you need to cancel or reschedule the appointment so that another patient who needs help can be seen.
It is the policy of this office: A $25.00 charge will be administered for each "No-Show" appointment, and will need need to be paid before another appointmnet will be scheduled. Patients may also be dismissed from the practice after their third "no-Show" in a 12 month period. The siblings will also be dismissed. Please Note:If there are (4) "No-Show" appointments in a family the family will be dismissed.

Patient/Guardian signature: ________________________________ Date: _______________