Pediatrics at Cherry Creek **Pediatrics at Stapleton Plaza**

2016 Patient Data Form

INDEX: _____ **Date Completed:** _____

PCP: ☐ Staerz (Cherry Creek) ☐ England (Stapleton) ***PLEASE PRINT ALL INFORMATION***

Patient's Legal Name	Gender	Date of Birth	Scanned

All patients under the age of 18 MUST be accompanied by a parent or legal guardian at EVERY VISIT.

Parents / Responsible Parties / Legal Guardians / Patient (if 18 or older)

Name:			Relationship to Patient(s): ☐ Mother ☐ Father ☐ Other _____ Lives with Patient? ☐ Yes ☐ No
DOB:	Gender: M F		Social Security No:
Mailing Address:			
Phone Number(s)	Home: (ok to leave message?) ☐ Yes ☐ No		Cell: (ok to leave message?) ☐ Yes ☐ No
Email:		Employer:	
Primary Contact/Financially Responsible: ☐ Yes ☐ No			
Name:			Relationship to Patient(s): ☐ Mother ☐ Father ☐ Other _____ Lives with Patient? ☐ Yes ☐ No
DOB:	Gender: M F		Social Security No:
Mailing Address:			
(if different from above)			
Phone Number(s):	Home: (ok to leave message?) ☐ Yes ☐ No		Cell: (ok to leave message?) ☐ Yes ☐ No
Email:		Employer:	
Primary Contact/Financially Responsible: ☐ Yes ☐ No			
OTHER EMERGENCY CONTACT:			Relationship to Patient(s): Lives with Patient? ☐ Yes ☐ No
DOB:	Gender: M F		Social Security No:
Mailing Address:			
(if different from above)			
Phone Number(s)	Home: (ok to leave message?) ☐ Yes ☐ No		Cell: (ok to leave message?) ☐ Yes ☐ No
Email:		Employer:	
Primary Contact/Financially Responsible: ☐ Yes ☐ No			
Can Person Provide Consent for Treatment?: ☐ Yes ☐ No			

Consent to Treat: I hereby consent to the treatment of the above listed patient(s) as the parent or legal guardian of the patient(s). I further understand that I must submit in writing, in advance, my approval for anyone else to bring the patient(s) for services, such as nannies, grandparents or other relative, prior to services being rendered.

Health Insurance Portability and Accountability Act (HIPAA): I consent to the use or disclosure of protected health information (PHI) by Pediatrics at Cherry Creek (dba Pediatrics at Stapleton Plaza) for the purpose of diagnosing or providing treatment of the above listed patient(s), obtaining payment for health care bills or to conduct health care operations. I understand that I have a right to review Pediatrics at Cherry Creek's Notice of Privacy Practices prior to signing the document.

Insurance Information: ***(You must have your insurance card available at EVERY visit.)***

Primary Insurance (commercial)	Insurance Company:	
	Subscriber Name:	DOB:
Secondary Insurance (commercial	Insurance Company:	
	Subscriber Name:	DOB:
ONLY If Medicaid or CHP eligible:		
Medicaid	Custodial/Responsible Parent:	
CHP+	Custodial/Responsible Parent:	

Financial Responsibility: As a courtesy to our patients, we will attempt to verify the patient(s) coverage and bill the insurance company on your behalf. I authorize my insurance company to pay Pediatrics at Cherry Creek all insurance benefits otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all charges whether or not I have active insurance. I authorize the use of this signature on all insurance submissions and authorize the health care provider to release the minimum necessary information needed to secure payment of benefits.

All copays are due at the time of visit. Many insurance companies have additional requirements or limits that may affect your coverage such as network limitations, prior authorization, visit limits, or other care limits. If your insurance carrier denies any part of your claim, or you choose to receive treatment beyond the limits of your health plan, you will be completely responsible for payment of this care.

I also understand that any changes to my insurance coverage or contact information will be reported to Pediatrics at Cherry Creek within 30 days of effective date. I agree that I will pay my outstanding balances (including deductibles, copays, coinsurance, etc.) within 30 days of invoice (unless prior arrangements have been made) or risk dismissal and/or third-party collections. Failure to provide prompt response to a past due statement may result in that account being turned over to a collections agency. Any family referred to a collection agency will be dismissed from our practice.

Attendance Policy: We allocate a specific time for your appointment to meet your child's anticipated needs. We understand that there may be times when you may miss an appointment, but if you fail to provide us with at least 4-hour advance notice of cancellation, you can be charged $20 for the missed appointment which will not be paid by your health plan. If you are more than 20 minutes late for your appointment, you may be required to reschedule the appointment for a later date. After three missed appointments, we may dismiss your children from the practice.

_____ _____

Signature of Parent or Legal Guardian Date Signed